

174X
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07275									
CERTIFICATE OF DEATH									
07271									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Helen			McCollough Allard			MAY 21 1969		10:40 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
F		W		Sept. 17, 1902		66 YRS.		MDNTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
New York		U.S.A.				Prince George			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
College Park		6300 Tecumseh Pl.		Teller		Bank			
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET AND NUMBER			
New York		Voorheesville		YES <input type="checkbox"/> NO <input type="checkbox"/>		5 Forest Road			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
John McCollough			Mary Hill						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
NO			093 18 6655		Mrs. Joan Weisgerber		Same as #10 & 11		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma</u>								18 mos.	
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Adenocarcinoma of Breast</u>								34 yrs.	
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M.							
		19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Feb 1969, to 5/21, 1969, that (I) (we) last saw the deceased alive on 5/19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
G. Lennard Gold		5/21/69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
G. Lennard Gold		9801 Ga. Ave., Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		May 24, 1969		St. Agnes		Albany		N. Y.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Francis J. Collins		MAY 23 1969		[Signature]					
500 University Blvd. Silver Spring, Md.									

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RECEIVED BY MAIL

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6 Film G 413
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <u>5-29</u> 19 <u>69</u>		2b. HOUR 1:10 P M	
Joseph		GID		Alvarez							
3. SEX M	4. RACE W	5. DATE OF BIRTH <u>12-18-1910</u>		6. AGE (In years last birthday) <u>58</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month <u>5</u> Day <u>29</u> Year <u>69</u>	
7a. BIRTHPLACE (State or foreign country) <u>FLORIDA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Prince George</u>				Md.	
10. CITY OR TOWN OF DEATH <u>RIVERDALE</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>LELAND MEMORIAL HOSP</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>AUTO MECHANIC</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>GARAGE</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Howard</u>		13c. CITY OR TOWN <u>Laurel</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>1409 Scaggsville Rd.</u>			
14. FATHER'S NAME First Middle Last <u>unknown</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>unknown</u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16b. SOCIAL SECURITY NO. <u>1929-1961</u>		17. INFORMANT <u>Joseph A Alvarez</u>		ADDRESS <u>- abame</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>unknown</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Min.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John Kehoe</u>		EXAMINER'S NAME (Type) <u>John Kehoe, M.D., Riverdale</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>5-3069</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6/3/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) <u>Arlington Va.</u>		(County)		(State)	
24. FUNERAL DIRECTOR <u>Carrollan Funeral Home</u>		ADDRESS <u>Laurel</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 5 1969</u>		25b. REGISTRAR'S SIGNATURE <u>John S. Jones</u>					

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07277

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07274

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Helen P. Arey			2a. DATE OF DEATH Month Day Year May 30 1969		2b. HOUR 10:15 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH 4-17-13		6. AGE (In years last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. COUNTY OF DEATH Prince George's		10. CITY OR TOWN OF DEATH Cheverly			
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hospital Prince George's		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Librarian		12b. KIND OF BUSINESS OR INDUSTRY Library	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. CITY OR TOWN P. G. Greenbelt		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13d. STREET AND NUMBER 6164 Springhill Terrace		14. FATHER'S NAME First Middle Last James I. Pyle			
15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Weaver		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no			
16b. SOCIAL SECURITY NO. 167 14 0484		17. INFORMANT Wesley A. Sweat Jr. Greenbelt, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF (b) Subarachnoid Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Ruptured Berryaneurism					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 10, 1969</u> , to <u>May 30, 1969</u> , that (I) (we) last saw the deceased alive on <u>May 30, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) Till Bergemann M.D.		22e. ADDRESS Professional Building Centenary Greenbelt			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/4/69		23c. NAME OF CEMETERY OR CREMATORY Lancaster Cemetery	
23d. LOCATION (City or town) (County) (State) Lancaster Pa.		24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR JUN 2 1969	
25b. REGISTRAR'S SIGNATURE 					

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07278		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07275	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	
WILLIAM HENRY ATKINSON						MAY 4 1969	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	
MALE		CAUCASIAN		12 DEC 1897		71 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
MISS.		U.S.				PRINCE GEORGES Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
GREENBELT		10-C HILLSIDE RD		DRAFTSMAN		U.S. GOVT.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		PRINCE GEORGES		GREENBELT		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	
10-C HILLSIDE ROAD		UNKNOWN		UNKNOWN		16b. SOCIAL SECURITY NO. 427-26-1477	
				17. INFORMANT		Address	
				MARY E. ATKINSON		SAME AS # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT 4109 DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost. ARTERIOSCLEROTIC HEART DISEASE (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CARCINOMA OF LARYNX							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Feb 1969, to 4 MAY 1969, that (we) (we) saw the deceased alive on April 1969, and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (we) view the body after death.							
22b. SIGNATURE Arthur Kaufman, M.D.				22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)	
				22e. ADDRESS		115 Centerway Rd. Greenbelt, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		5-7-1969		FORT LINCOLN CEM		COLMAR MANOR, MARYLAND	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W.W. CHAMBERS Co, RIVERDALE, MD.				MAY 8 1969		W.W. Chambers	

WILLIAM HENRY ATKINSON

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07279

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07276

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
Mabel E. Bacigaluppi						5/11/69 Month Day Year			5:40 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
F		W		7/13/1887			81 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Prince Georges Co.		USA				Prince Georges County Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince Georges Hospital			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MD			PG		District Hghts.		YES <input type="checkbox"/> NO <input type="checkbox"/>		7306 Gateway Boulevard	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Benjamin F. Richardson			Georgia A. Pope							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT					
no			-		Joseph Bacigaluppi, Son 9103 Sheridan Ct., Sea Brook, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASHD with Myocardial Infarction</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>plus Chronic Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>4-3</u> , 19 <u>67</u> , to <u>May 11</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>May 11</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED								
John F. Hay		5-12-69								
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
		5509 Old Shober Hill Rd. Suitland, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		5/14/69		Washington National		Suitland, Md.				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Robert E. Wilhelm Funeral Home		MAY 15 1969		James J. Judge						
4308 Suitland Rd., S.E., Suitland, Md., 20023										

...and the ...

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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07280

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07277

1 DECEASED NAME (Type or Print)		First Middle Last		2a. DATE KNOWN OF DEATH		Month Day Year		2b. HOUR OF DEATH	
Clarence		Walter Bailey		5		3 1969		6:20 am	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR	8 UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		2d. HOUR OF DEATH	
M	W	23 July 1895	73 YRS	MONTHS DAYS	HOURS MIN.	Month 5 Day 3 Year 1969		6:20 am	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md	
Conn.		U. S. A.				Prince George			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George Hosp		Ret. Painter		Constructive			
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md		Prince George Forestville		Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/>				7325 Cross Street	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		First Middle Last		First Middle Last			
Charles F. Bailey		Fannie Braze							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Yes		WW 1		223 10 4882		Clara E. Bailey Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									Min.
4 13 Heart failure									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.									Yrs.
(b) Arteriosclerotic heart disease									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
Multiple rib fractures									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		9:45 PM 4 27 19 69		Passenger in car which overturned.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
		Street		St Rt 4, near Woodyard Rd.		P.G.		Md.	
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22b. DATE SIGNED		5-3-69		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE		John Kehoe, M.D., Riverdale		ADDRESS (Street, city, town, or county)					
EXAMINER'S NAME (Type)									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATION		23d. LOCATION (City or Town)		(County) (State)	
Burial		5/7/69		Calvary Meth. Church		Stuarts Draft Augusta		Va.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG STR		25b. REGISTRAR'S SIGNATURE			
Francis Gasch's Sons		Hyattsville, Md.		MAY 7 1969		John Kehoe			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1572
45M - 1X69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last Norma M. Baker			2a. DATE OF DEATH Month Day Year May 5 1969			2b. HOUR 12:52 P.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH 05-01-1927		6. AGE (in years last birthday) 42 YRS.		7. UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.		12a. OCCUPATION (Kind of work done during most of working life even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institut on admission) STATE MD		13b. COUNTY Prince George's		13c. CITY OR TOWN Hillside		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1103 57th Ave.			
14. FATHER'S NAME First Middle Last Louis Nies			15. MOTHER'S MAIDEN NAME First Middle Last Bernice Lang								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO		17. INFORMANT Roy Baker		Address Spring 23 Above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Myocardial infarction +104 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Brain Stem hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from May 3, 1969 to May 5, 1969, that (I) (we) last saw the deceased alive on May 5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE P.C. Xavier, M.D.		DEGREE P.C. Xavier, M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED May 5, 1969					
22d. PHYSICIAN'S NAME (Type) P.C. Xavier, M.D.		22e. ADDRESS Prince George's Gen. Hosp.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/8/69		23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Md					
24. FUNERAL DIRECTOR Scarrelli Funeral Home Cumberland, Md.		ADDRESS		25a. RECD BY REGISTRAR DATE MAY 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					



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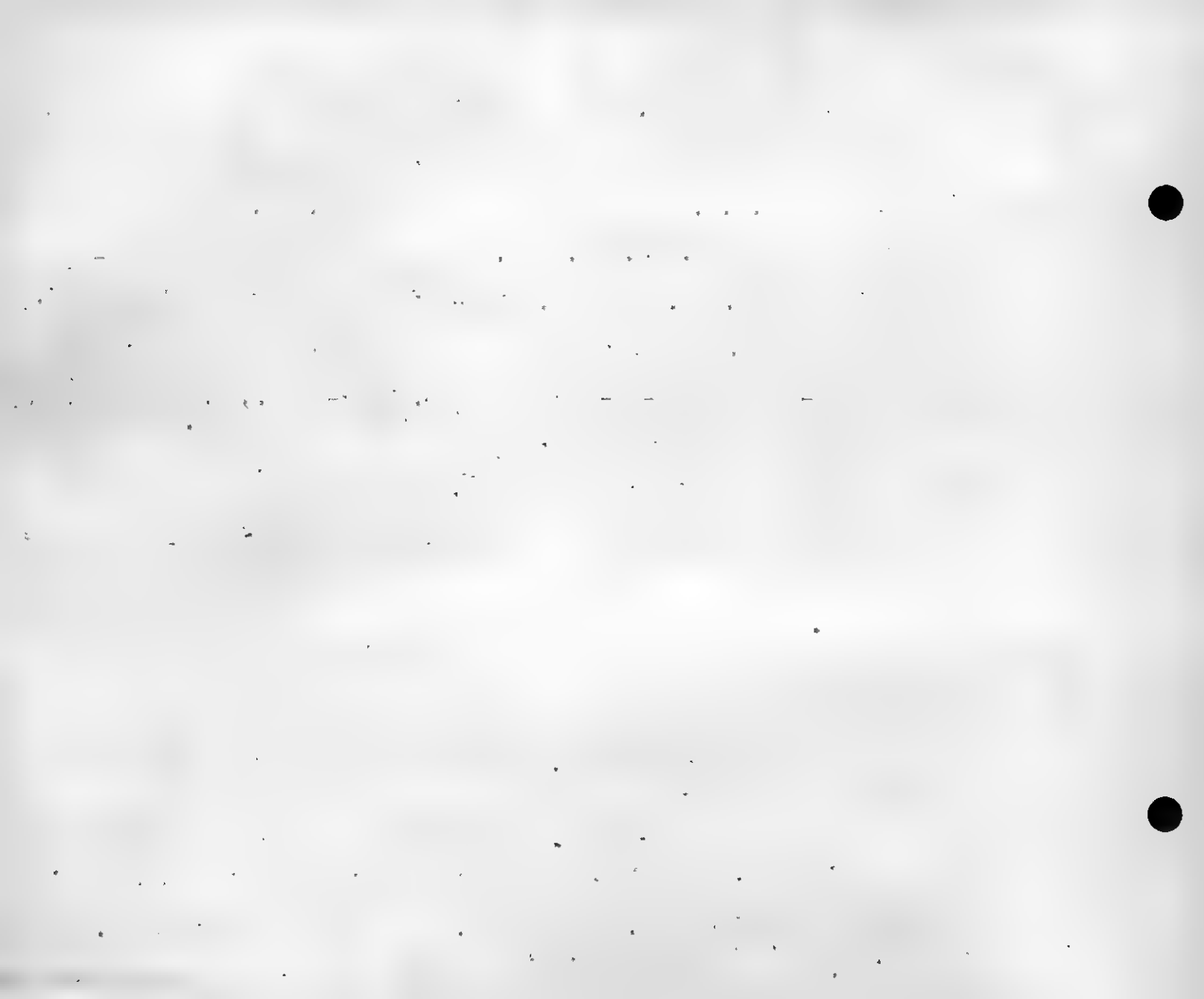
07282		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07279	
1 DECEASED NAME (Type or print)				2a. DATE OF DEATH		2b. HOUR	
Doris Lucille Bartholemew				May 8 1969		5:05 PM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)	
Female		White		10-25-10		58 YRS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
Iowa		U.S.A.		Prince George's		Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George's Gen. Hosp.		Ret. Secretary		G.C.S.	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b CITY OR TOWN		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MD		Prince George's Greenbelt				2 A Eastway Road	
14 FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last			
Thomas C. Olds				Belle Simpson			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT			
no				Thomas R. Bartholomew Bowie, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Acute intracerebral hemorrhage; left</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>Metastatic CA to liver and peritoneum</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1965 to May 8, 1969, that (I) (we) last saw the deceased alive on May 8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Hans Wodak M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5-9-1969	
22d. PHYSICIAN'S NAME (Type) HANS WODAK M.D.				22e. ADDRESS GREENBELT, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		5/12/69		Oakland Cemetery		Centerville Appanoose Iowa	
24. FUNERAL DIRECTOR F. Basch's Sons, Hyattsville, Md				25a. REC'D BY REGISTRAR MAY 13 1969		25b. REGISTRAR'S SIGNATURE	

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VR A1514
30M REV 9/68

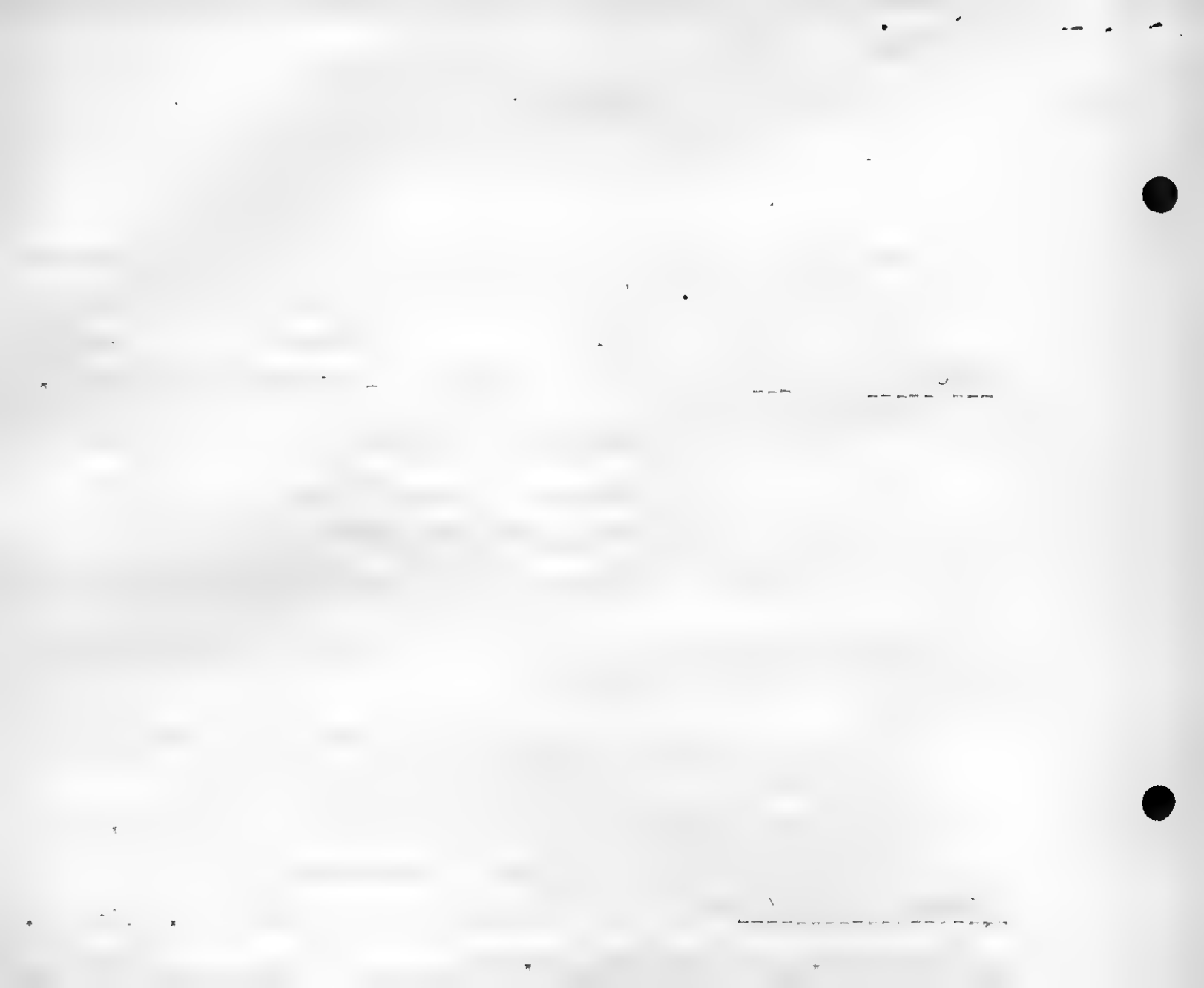
07283										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07280																													
Item 6 Film 412 5/12/69 kk										CERTIFICATE OF DEATH																																							
1 DECEASED NAME (Type or print) First Middle Last Ada D. Bock										2a. DATE OF DEATH Month Day Year May 1 1969										2b. HOUR 8:05 PM																													
3 SEX Female										4 RACE White										5. DATE OF BIRTH 4/29/1880										6 AGE (In years last birthday) 88 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN									
7a BIRTHPLACE (State or foreign country) Indiana										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Pr. Geo. Md.																			
10. CITY OR TOWN OF DEATH Cheverly										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo. Gen. Hosp.										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife										12b KIND OF BUSINESS OR INDUSTRY -																			
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland										13b. COUNTY Pr. Geo.										13c CITY OR TOWN Mt. Rainier										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e STREET AND NUMBER 3007-Bunker Hill Rd.									
14. FATHER'S NAME First Middle Last James P. Rader										15. MOTHER'S MAIDEN NAME First Middle Last Alice Schertzer										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No										16b. SOCIAL SECURITY NO. 218-38-9106										17. INFORMANT Address Carl L. Bock- Ave., Landover Hills, Md. 4213- 72d									
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY THROMBOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIO SCLEROTIC HEART DISEASE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>1 WEEK</u> <u>1 MONTH.</u>																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																	
19a DATE OF OPERATION 4/4/69										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CHOLECYSTITIS										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 5, 1969</u> to <u>MAY 1, 1969</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>MAY 1, 1969</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) <u>(did not)</u> view the body after death.																																																	
22b. SIGNATURE <u>Samuel J.N. Sugar</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <u>May 2, 1969</u>																													
22d. PHYSICIAN'S NAME (Type) SAMUEL J.N. SUGAR, M.D.										22e. ADDRESS 4637 EASTERN AVE., WASH., D.C. 20018																																							
23a BURIAL CREMATION REMOVAL Burial										23b. DATE 5/5/1969										23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.										23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.																			
24 FUNERAL DIRECTOR Nalley's Funeral Home Inc.										ADDRESS Mt. Rainier, Maryland										25a REC'D BY REGISTRAR MAY 6 1969										25b. REGISTRAR'S SIGNATURE <u>Glenn J. Judge</u>																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
07284 CERTIFICATE OF DEATH 07281											
1. DECEASED-NAME (Type or print) First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR					
Anka Hannah Bond			5 9 69			10:55 A M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN	
Female		White		2-6-1883		86 YRS.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
VA.			USA						Prince George Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tal give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Clinton, Md.			Pineview Gardens			Housewife			Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Pr. Geo's			Brandywine		YES		Box 103 Doyson Road	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
John Goode			Theresa Butts								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
James Bond						James Bond- BERNARD			Brandywine, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer arrest.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF										1 min.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause										1 min.	
(b) <u>Coronary embolism</u>											
DUE TO, OR AS A CONSEQUENCE OF										12 yrs	
(c) <u>Coronary heart disease</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerosis Cardiovascular disease</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6-11, 1968, to 5/9, 1969, that (I) (we) last saw the deceased alive on 5/8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED								
Alfred R. Lapin M.D.			May 9, 1969								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
ALFRED R. LAPIN M.D.			Clinton, Md.								
23a. BURIAL - CREMATION			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			5/13/69			Cedar Hill Cemetery			Suitland Pr. Geo's Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REG STRAR DATE			25b. REGISTRAR'S SIGNATURE		
Ritchie Bros.			Upper Marlboro, Md. 20870			MAY 13 1969			Charles N. Jones		



07285

CERTIFICATE OF DEATH

07282

1. DECEASED-NAME (Type or print)		First Aristide	Middle L.	Last Borelli	2a. DATE OF DEATH Month Day Year May 10, 1969		2b. HOUR 4:40AM
3 SEX Male	4. RACE White	5. DATE OF BIRTH 9/8/92		6 AGE (n years last birthday) 76 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Italy	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's			
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Stone Mason		12b. KIND OF BUSINESS OR INDUSTRY US Gov't		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE District of Col.		13b. CITY OR TOWN Dist. Of Columbia		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3529 Highwood Drive, S.E.	
14. FATHER'S NAME First Middle Last Giacchino - Borelli		15. MOTHER'S MAIDEN NAME First Middle Last Francesca - Palmieri					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes give war or dates of service		16b. SOCIAL SECURITY NO.		17. INFORMANT Francis Borelli 11011 Bennington Dr Upper Marlboro			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Failure</u>							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							
(b) <u>Emphysema, Pneumonia</u>							
(c) <u>Chronic Bronchitis</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) was <u>was</u> attended the deceased from <u>3:5</u> , 19 <u>62</u> , to <u>May 10</u> , 19 <u>69</u> , that (I) we <u>we</u> lost saw the deceased alive on <u>5-9</u> 19 <u>69</u> , and that in (my) our <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) we <u>we</u> (did) (did not) view the body after death.							
22b. SIGNATURE <u>M. Kemal Mutlu M.D.</u>				22c. DATE SIGNED May 10, 1969			
22d. PHYSICIAN'S NAME (Type) M. Kemal Mutlu, M.D.				22e. ADDRESS 4900 Silver Hill Rd., Suitland, Md. 20023			
23a. BURIAL, CREMATION, BURNING (Specify)		23b. DATE May 13, 1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg Maryland	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland				25a. REC'D BY REGISTRAR MAY 14 1969		25b. REGISTRAR'S SIGNATURE <u>James H. Gage</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07286

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

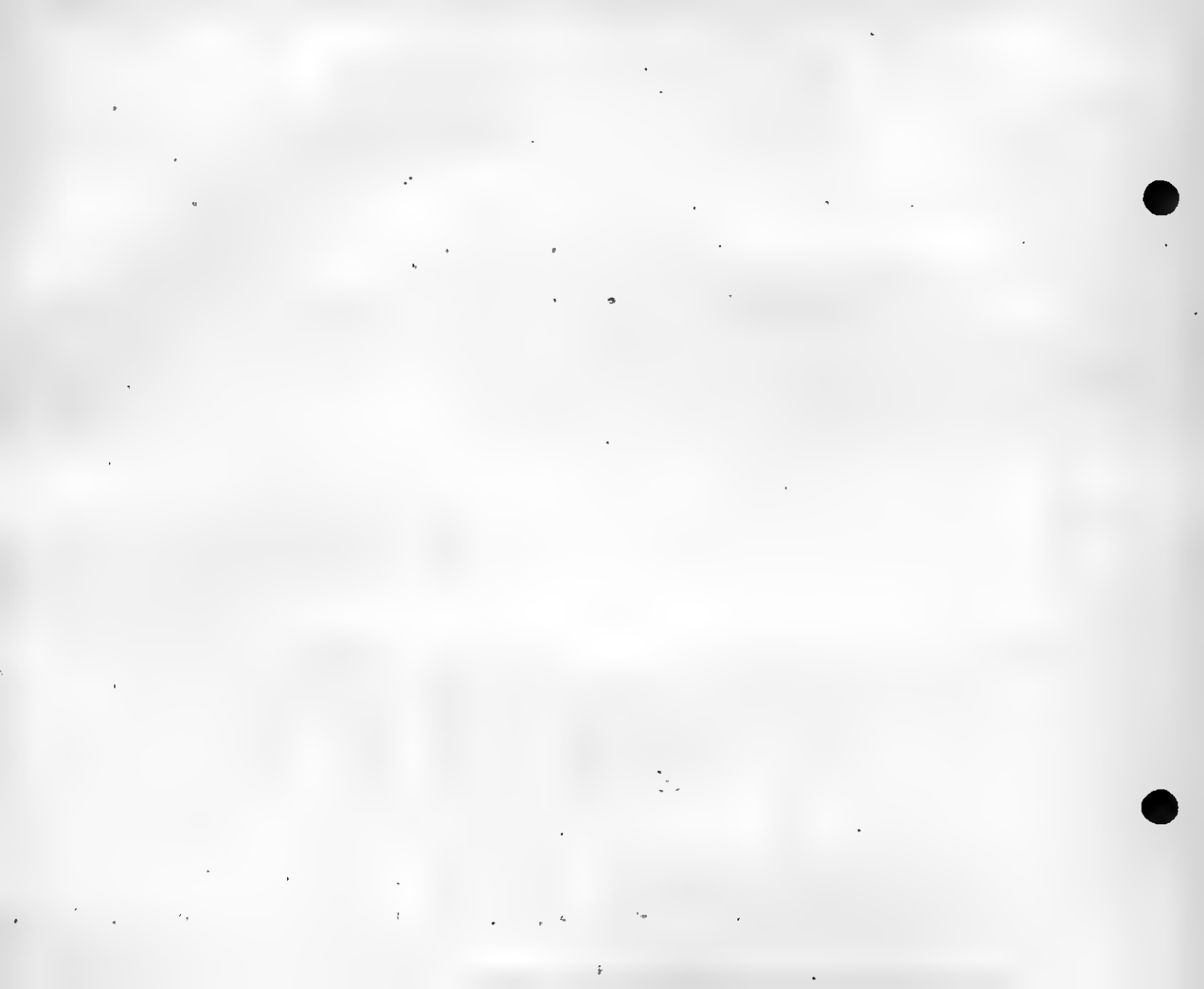
07283

1 DECEASED NAME (Type or Print)		First Stanley		Middle Howard		Last Bossert		2a DATE KNOWN OF DEATH EST. <input type="checkbox"/> Month Day Year MATED <input checked="" type="checkbox"/> 5 21 1969				2b HOUR 4:26 PM			
3 SEX M	4 RACE W	5 DATE OF BIRTH 26 Aug., 1951		6 AGE (In years lost birthday) 14 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month 5 Day 21 Year 19 69				2d HOUR 4:26 PM	
7a BIRTHPLACE (State or foreign country) Pa.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges								Md.	
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hosp				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student				12b KIND OF BUSINESS OR INDUSTRY N/A					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Prince George Bowie		13c CITY OR TOWN		13d INSIDE CITY L.M. 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 12118 Sandal Lane							
14 FATHER'S NAME First John		Middle Lewis		Last Bossert		15 MOTHER'S MAIDEN NAME First Lucretia		Middle -		Last Vincent					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		(If yes give year or dates of service) ---		16b SOCIAL SECURITY NO None		17 INFORMANT John L. Bossert, Same as # 13									
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1709 Metastatic sarcoma DUE TO, OR AS A CONSEQUENCE OF (b) Ewing's sarcoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 5 yrs.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No City or Town County State											
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John Kenoe, M.D., M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 5 21 69	
ADDRESS(Street, city, town, or county) Prince Georges Co.															
23a BURIAL CREMATION Burial		23b DATE 5/23/69		23c NAME OF CEMETERY OR CREMATORY Arlington National Cem.				23d LOCATION (City or Town) (County) (State) Arlington Arlington Va.							
24 FUNERAL DIRECTOR Joseph Gawler's Sons						ADDRESS 5130 Wisconsin Ave., N.W. Washington, D. C.		25a REC'D BY REGISTRAR DATE MAY 23 1969		25b REGISTRAR'S SIGNATURE Charles Judge					



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First Baby		Middle Girl		Last Bosworth		2a. DATE OF DEATH Month May Day 17, Year 1969		2b. HOUR 2:00P M		
3 SEX Female			4. RACE Colored			5. DATE OF BIRTH May 17, 1969			6. AGE (In years last birthday) YRS MONTHS DAYS 5 10		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN 5 10		
7a. BIRTHPLACE (State or foreign country) Prince George's			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md.				
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ---			12b. KIND OF BUSINESS OR INDUSTRY ---				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Prince George's			13c. CITY OR TOWN Landover			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7210 Chesapeake St.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 777X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (A) (this hospital) attended the deceased from <u>May 17</u> , 19 <u>69</u> , to <u>May 17</u> , 19 <u>69</u> , that (X) (we) lost saw the deceased alive on <u>May 17</u> , 19 <u>69</u> , and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Hugh Clark</u>			22c. DATE SIGNED <u>May 18 1969</u>			22d. PHYSICIAN'S NAME (Type) Dr. Hugh Clark			22e. ADDRESS 7309 Riggs Rd. Hyattsville				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE 5-24-69			23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital			23d. LOCATION (City or Town) (County) (State) Cheverly, Prince George's, Md.				
24. FUNERAL DIRECTOR <u>Harry W. Penn, Jr.</u>			25a. REC'D BY REGISTRAR DATE MAY 28 1969			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07288		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07285	
Item 5 Film 412 5/12/69 kk					
1. DECEASED NAME (Type or print) First Middle Last FRANK XXXXXXXX Bourell			2a. DATE OF DEATH Month 5 Day 3 Year 1969		2b. HOUR 20 M
3 SEX Male	4 RACE W	5. DATE OF BIRTH 3/29/1890 15/18/1890		6 AGE (In years last birthday) 79 YRS	IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MASS.	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.	
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pineview Gardens		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Carpenter	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE Del.		13b. COUNTY PG	13c. CITY OR TOWN P.C.	13d. INSIDE CITY (In 157) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5501 Parkland Ct. SE
14. FATHER'S NAME First Middle Last Frank Bourell		15. MOTHER'S MAIDEN NAME First Middle Last Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. 577-24-9130		17 INFORMANT Address A Vincent Cook, Step-Son	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CARDIAC ARREST.</u> 4123 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIO SCLEROTIC HEART DISEASE</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>FEW MINUTES.</u> <u>3 DAYS.</u> <u>FEW YEARS.</u>
PART 2 OTHER SIGNIFIKANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CEREBRAL VASCLULAR ACCIDENT</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>7-16-68</u> , 19 <u>68</u> , to <u>5-3</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-3</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. Mostaan, M.D.				22c. DATE SIGNED 5-3-69	
22d. PHYSICIAN'S NAME (Type) REZA MOSTAAN, M.D.				22e. ADDRESS 11 Miss Ave. S.E. WASHINGTON DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/6/69		23c. NAME OF CEMETERY OR CREMATORY Washington National	
23d. FUNERAL DIRECTOR Robert L. Wilhelm Funeral Home		23e. ADDRESS 2303 Suitland Rd., S.E., Suitland, Md., 20023		23f. LOCATION (City or Town) (County) (State) Suitland, Maryland, 20023	
24. REGISTRAR MAY 8 1969				25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07289									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)					2a DATE OF DEATH			2b HOUR	
First Middle Last ANNA K. BRAASCH					Month Day Year MAY 20 1969			3:00 PM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR	
FEMALE		CAUCASIAN		2-21-98		71 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		10	
New Jersey		U.S. A				Prince George		Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Forestville		Regent		Housewife					
13a USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.		Prince George District		Forestville				7215 Foster St.	
14. FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last					
William H. Karrer				Elizabeth Hughes					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service)				16b SOCIAL SECURITY NO		17 INFORMANT			
Yes				NW 1		George H. Braasch. 1234 Chalmers Drive Battle Creek, Mich.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>									
4172 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Insufficiency</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>High fever, pneumonia, Central thrombosis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-2-1969</u> to <u>5-20-1969</u> , that (I) (we) last saw the deceased alive on <u>5-19-69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Oliver B. Bond</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>MAY 20-1969</u>			
22d. PHYSICIAN'S NAME (Type) <u>OLIVER B. BOND</u>				22e. ADDRESS <u>7420 MARLBORO PIKE FORESTVILLE MD 20028</u>					
23a. BURIAL, CREMATION, OR OTHER DISPOSAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		May 23-69		Cedar Hill Cemetery		Suitland, Maryland			
24. FUNERAL DIRECTOR <u>Simmons Bros</u>				ADDRESS <u>1661-Gd. Hope Rd. SE Wash., DC</u>		25a. REC'D BY REGISTRAR <u>MAY 23 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
07290		CERTIFICATE OF DEATH						07287		
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR P M	
Angeline			E Bradshaw			May 20 1969			9:20 P M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		7. UNDER 1 YEAR MONTHS DAYS	
Female		White		June 20, 1877			91 YRS.		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH	
District of Columbia			United States			Prince George			Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Hyattsville			Sacred Heart Home			Housewife			-	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13d. STREET AND NUMBER	
District of Columbia			Washington			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1226 Saratoga Ave., N.E.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
John Richard Phillips			Agnes Ebert							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			Address	
No			217-30-3557			Sacred Heart Home, Hyattsville, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart Failure</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Acute Fibullectus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Senescent Arteriosclerotic Cardio-Vascular Disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 year</u> <u>5 year</u> <u>15 year</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>65</u> , to <u>5-20</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-1</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>[Signature]</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>5-20-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>O-SAHAKIAN</u>					22e. ADDRESS <u>6001 Landover Rd Chevy Chase</u>					
23a. BURIAL, CREMATION, BURNING (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County) (State)	
Burial		5/23/69		Mt. Olivet Cem.			Wash., D.C.			
24. FUNERAL DIRECTOR Home Inc.					Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR DATE <u>MAY 26 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers 1, 2 and 3 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07291										07288									
Item 5 Film 4112 5/9/69 kk										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print) First Middle Last <i>Paula L. Brann</i>					2a. DATE OF DEATH Month Day Year <i>May 2 1969</i>					2b. HOUR <i>7:50 A.M.</i>									
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>July 11, 1891</i>			6. AGE (in years last birthday) <i>77</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN							
7a. BIRTHPLACE (State or foreign country) <i>Berlin Germany</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>Prince George's</i> Md													
10. CITY OR TOWN OF DEATH <i>Forestville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Heaght Nursing Home</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institut any Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>Bay Ridge</i>		13c. CITY OR TOWN <i>Bay Ridge</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>702-44th St.</i>											
14. FATHER'S NAME First Middle Last <i>Edgar unknown</i>					15. MOTHER'S MAIDEN NAME First Middle Last <i>Toni Sklarz</i>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Eva Toni Brann, Daughter 217 Hanover St., Annapolis, Md.</i>												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma Rt. Lung</i> 174A DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma Rt. Breast</i> DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 YR</i> <i>9 YRS.</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Parkinson's disease</i>																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)															
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct. 5, 1967</i> , to <i>May 2, 1969</i> , that (I) (we) last saw the deceased alive on <i>Apr. 28, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <i>Walter B. Sheer M.D.</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <i>May 2, 1969</i>									
22d. PHYSICIAN'S NAME (Type) <i>WALTER B. SHEER</i>					22e. ADDRESS <i>6400 MARLBORO PIKE S.E. WASH. DC.</i>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5/5/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Knolwood Park Cemetery</i>				23d. LOCATION (City or Town) (County) (State) <i>New York City, New York</i>											
24. FUNERAL DIRECTOR <i>Robert E. Wilhelm Funeral Home</i> <i>4305 Suitland Rd., S.E., Suitland, Md., 20023</i>						25a. REC'D BY REGISTRAR <i>MAY 5 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>											

7.



FOR STATE
HEALTH DEPT.

07292

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

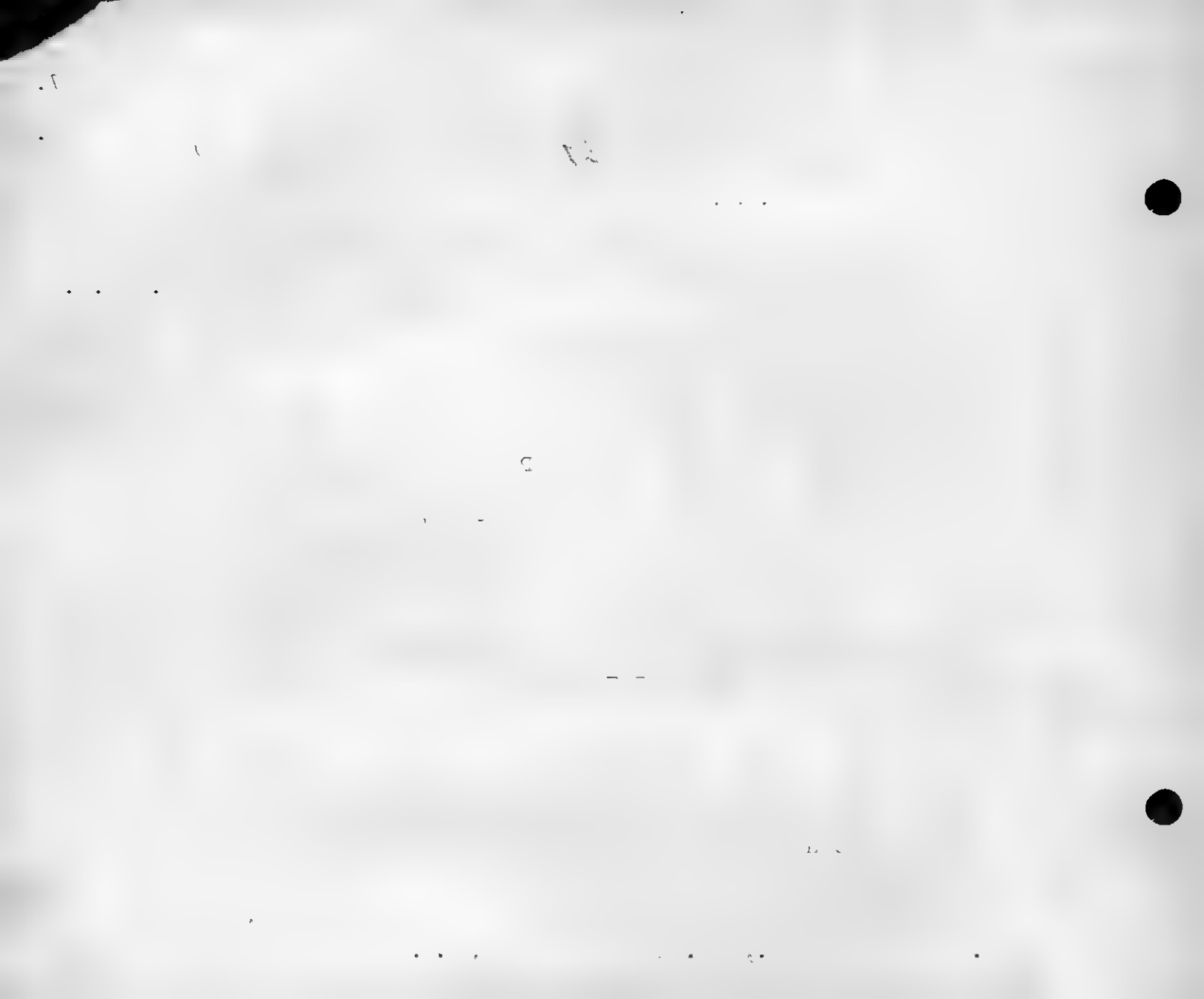
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07289

1. DECEASED-NAME (Type or Print)		First Lucille Middle M.dle Last Brent		2a. DATE KNOWN OF DEATH		Month 5 Day 7 Year 69		17 1:25 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. UNDER 1 YEAR	8. UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		2d. HOUR	
F	Negro	# 3 Feb 1910	57 YRS	MONTHS	DAYS	MONTHS	Day 7 Year 1969	1:25 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		Md	
N. C.		U.S.A.				Prince George			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Glendale		Glendale Hosp		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
DC		Washington				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7135 8th St., N.W.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
First Middle Last		First Middle Last		no		unknown		Decedent	
Boyd -- Oldham		Mattie -- Roberts							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Acute renal failure							
DUE TO, OR AS A CONSEQUENCE OF		and Pulmonary edema						12 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)							
		DUE TO, OR AS A CONSEQUENCE OF		Burns-65-70% body surface				30 hrs	
		(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		Recurrent CVA's							
Hypertensive arteriosclerotic heart disease		yrs.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
		7:24am 5-6-69		Bed clothing caught fire from cigaret					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Glendale Hosp		Glendale		Prince George		Md	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from.		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
ACTUAL SIGNATURE		John Kehoe, M.D., Riverdale		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		5-7-69			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
		5/10/1969		Harmony		Landover, Maryland			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W. Ernest Jarvis Co., Inc.		1432 You Street, N.W.		DATE MAY 12 1969		McMullen Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

1

07293

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07290

1 DECEASED-NAME (Type or print) First Middle Last Mary Brown			2a. DATE OF DEATH May Month 4 Day Year 69		2b. HOUR 5:45a
3 SEX Female	4. RACE Negro	5. DATE OF BIRTH 09-09-14		6 AGE (In years last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) S.C.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Geo. Md		
10. CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen. Hosp.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Domestic	12b KIND OF BUSINESS OR INDUSTRY	
13a USJA RESIDENCE (Where deceased admission) STATE MD	13b COUNTY Prince Geo.	13c CITY OR TOWN Chapel Oaks	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 5906 Fairmont Gardens	
14 FATHER'S NAME First Middle Last Deceased		15 MOTHER'S MAIDEN NAME First Middle Last Deceased			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO	17 INFORMANT Glover C. Brown - 5904 - Bonhillery Ave. Address Hillside, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertension, Cardiovascular disease with DUE TO, OR AS A CONSEQUENCE OF congestive heart failure Condit ons, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Uremia Clinical DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or RFD No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from April 24, 1969, to May 4, 1969, that (I) (we) lost saw the deceased alive on May 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE S.V. Nair, M.D.		22c. DATE SIGNED May 5, 1969		22d. PHYSICIAN'S NAME (Type) S.V. Nair, M.D.	
22e ADDRESS Prince George's Gen. Hosp.		22f. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PARK			
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE 5/10/69	23c LOCATION (City or Town) (County) (State) Highland Park Md		23d
24. FUNERAL DIRECTOR Nancy S. Washington					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07294

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07291

1 DECEASED-NAME (Type or print) Patrick John Brown			2a. DATE OF DEATH Month May Day 10 Year 1969			2b. HOUR 10:30AM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH May 7, 1969		6. AGE (In years last birthday) YRS. 3	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none		12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Bladensburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last Kenneth D. Brown		15 MOTHER'S MAIDEN NAME First Middle Last Deborah K. Adams		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			
16b. SOCIAL SECURITY NO. none		17 INFORMANT Address Kenneth D. Brown same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Prematurity, 2200 grams 1167 DUE TO, OR AS A CONSEQUENCE OF (b) Atalectasis of Lungs DUE TO, OR AS A CONSEQUENCE OF (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 7, 1969 , to May 10, 1969 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 10, 1969 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE Hugh G. Clark				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED May 10 1969	
22d. PHYSICIAN'S NAME (Type) Hugh G. Clark				22e. ADDRESS Prince George Gen. Hospital-Cheverly, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 5/12/69		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons				ADDRESS H yattsville, Md.		25a. REC'D BY REGISTRAR MAY 14 1969	
						25b. REGISTRAR'S SIGNATURE William J. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07295		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07292	
CERTIFICATE OF DEATH					
1. DECEASED NAME (Type or print)		First REBECCA	Middle	Lost BROWN	2a. DATE OF DEATH Month MAY Day 13 Year 1969
3. SEX F	4. RACE C	5. DATE OF BIRTH 6-16-77		6. AGE (In years last birthday) 91 YRS.	2b. HOUR 4:45 A.M.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George Md		
1d. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pine View Gardens Rehab Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Dry worker	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Pr. Geo	13c. CITY OR TOWN Brandywine	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
14. FATHER'S NAME First Isiah Middle Brown Last		15. MOTHER'S MAIDEN NAME First Louise Middle Jones Last		Address Gen'l Del. way Upper Marlboro, Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Mrs. Gwendolyn Ford.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4124 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) cardiac atherosclerotic disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 2 days 2 wks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 2/29, 1968 , to 5/12, 1969 , that (I) (we) lost saw the deceased alive on 5/12, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Alfred R. Lapin		DEGREE ALFRED R. LAPIN		22c. DATE SIGNED 5/13/69	
22d. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN		22e. ADDRESS CLINTON, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 17-69		23c. NAME OF CEMETERY OR CREMATORY Forest Hill Garden Cem.	
24. FUNERAL DIRECTOR Marcell Adams		ADDRESS Aguasco, Md.		25a. REC'D BY REGISTRAR MAY 21 1969	
VR 155 45M - 1		25b. REGISTRAR'S SIGNATURE John...			

486X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

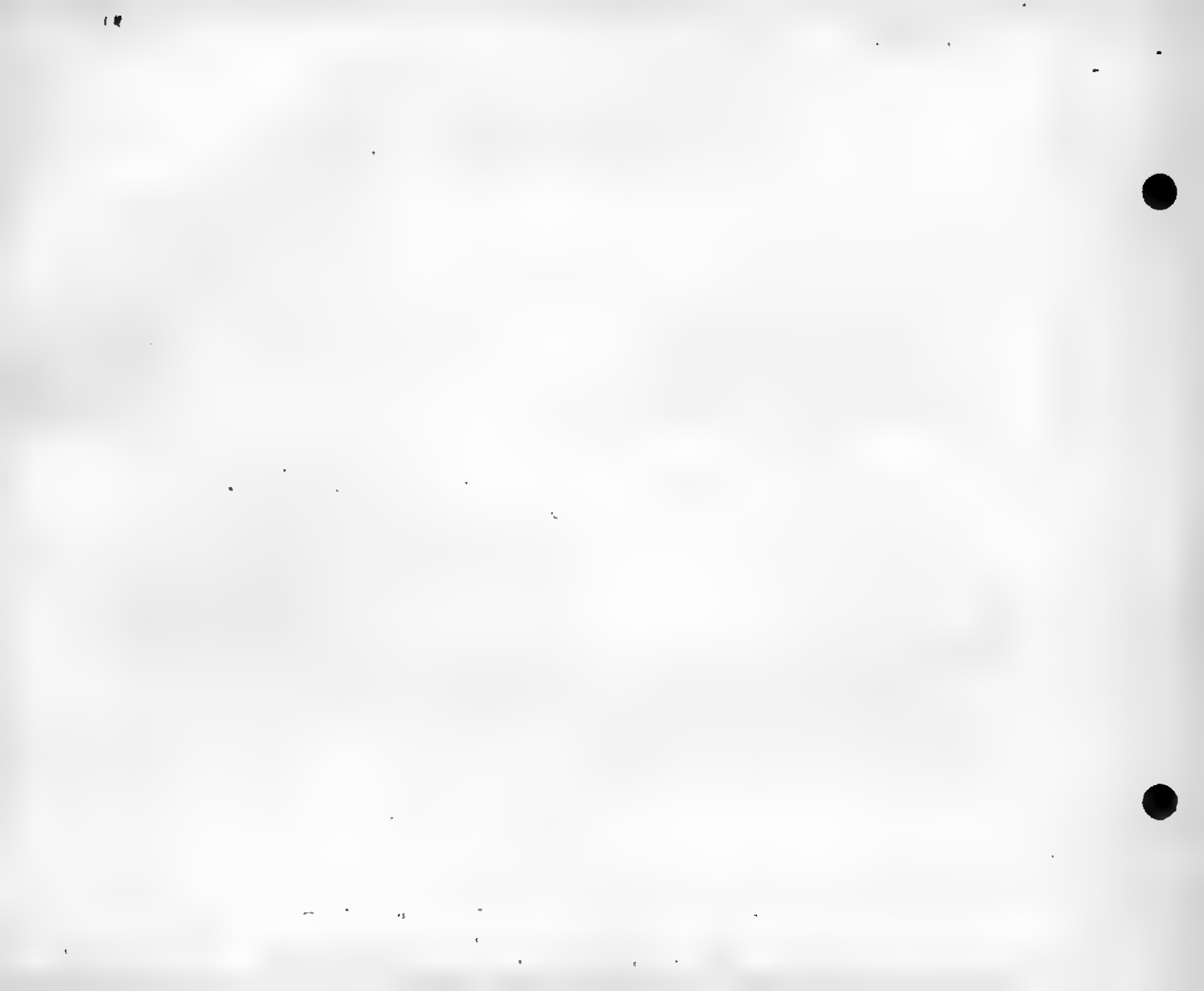
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)		First <u>Edgar</u>		Middle <u>Edgar</u>		Last <u>Browning</u>		2a DATE OF DEATH Month <u>5</u> Day <u>25</u> Year <u>69</u>	
3 SEX <u>Male</u>		4 RACE <u>White</u>		5 DATE OF BIRTH <u>11-10-80</u>		6 AGE (in years last birthday) <u>88</u> YRS		IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>	
7a BIRTHPLACE (State or foreign country) <u>ash, D.C.</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Prince Georges co.</u>		Md	
10 CITY OR TOWN OF DEATH <u>Cheverly</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Prince Georges Gen. Hosp.</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
13a US-JAL RESIDENCE (Where deceased lived, if institution. Residence before death) <u>Maryland</u>		13b COUNTY <u>Prince Georges</u>		13c CITY OR TOWN <u>Seat Pleasant</u>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <u>419 69th Place</u>	
14 FATHER'S NAME		First <u>Unknown</u>		Middle <u> </u>		Last <u> </u>		15 MOTHER'S MAIDEN NAME First <u>Hattie</u> Middle <u> </u> Last <u>Redding</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b SOCIAL SECURITY NO <u>578-03-0211</u>		17 INFORMANT Address <u>Pessie Browning Same as 13a</u>		13abode	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> 41.23 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE CORONARY HEART DISEASE 2 DAYS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PNEUMONIA, RT-LUNG</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>PULMONARY EMPHYSEMA</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-20</u> , 19 <u>69</u> , to <u>5-25</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-22</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Max M. Herzberg, M.D.</u>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5-26-1969</u>			
22d PHYSICIAN'S NAME (Type) <u>Dr. T. MAX</u>		HERZBERG		22e ADDRESS <u>3308 Dodge Park Road Landover, Md.</u>					
23a BURIAL OR CREMATION, REMOVAL (Specify)		23b DATE <u>5/28/1969</u>		23c NAME OF CEMETERY OR CREMATORY <u>Adair Hill</u>		23d LOCATION (City or Town) (County) (State) <u>Shiloh Park</u>			
24 FUNERAL DIRECTOR <u>Matthew 131-11th St. S.E. D.C.</u>		ADDRESS		25a REC'D BY REGISTRAR <u>MAY 28 1969</u>		25b REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) <i>Inery E. Bryant</i>					2a DATE OF DEATH 5 Month 7 Day 69 Year			2b HOUR 3:50 PM	
3. SEX <i>F</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>March 30, 1888</i>		6 AGE (In years last birthday) <i>81</i> YRS.		F UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince Georges</i> Md.			
10 CITY OR TOWN OF DEATH <i>Clinton, Md.</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Anne's Hospital</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Sales Lady</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Retail Store</i>			
13a U.S.A. RESIDENCE (Where deceased lived, if Institution: Residence before admission) STATE <i>DC</i>		13b COUNTY <i>13b</i>		13c CITY OR TOWN <i>Washington</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>915 Alabama Ave. SE</i>	
14 FATHER'S NAME <i>John Morgan</i>				15 MOTHER'S MAIDEN NAME <i>Rebecca Winston</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17 INFORMANT <i>Jean Headley - 124 Robert St. SE Md</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic Arrest</i> <i>4125</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Myocardial Infarction with Coronary</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Reclusion</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i> <i>2 months</i> <i>- 5 months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Arteriosclerosis Cardiovascular disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from <i>March 21, 1969</i> to <i>May 7, 1969</i> , that (I) (we) last saw the deceased alive on <i>3/7</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <i>Alfred R. Lapina</i>				22c. DATE SIGNED <i>5/7/69</i>		22d. PHYSICIAN'S NAME (Type) <i>ALFRED R. LAPINA</i>			
23a. BURIAL CREMATION <i>XXXXXX</i>		23b. DATE <i>May 10-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bethany Church Cemetery</i>		23d. LOCATION (City or Town) <i>Callao, Virginia</i>		23e. REC'D BY REGISTRAR <i>Charles Judge</i>	
24. FUNERAL DIRECTOR <i>Simmons Brothers</i>				ADDRESS <i>Wash., D.C.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>MAY 9 1969</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07298

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07295

1. DECEASED NAME (Type or print) First Middle Last David Buckbinder		2a. DATE OF DEATH 5 Month 18 Day 69 Year		2b. HOUR 10 ^{AM}
3. SEX Male	4. RACE White	5. DATE OF BIRTH 11-2-30	6. AGE (In years last birthday) 38 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) PAWTUCKET, R.I.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges Md.	
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges GROUP SUPERINTENDENT	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	2b. KIND OF BUSINESS OR INDUSTRY I.R.S.	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2804 Spind 1a
14. FATHER'S NAME First Middle Last Louis Buckbinder	15. MOTHER'S MAIDEN NAME First Middle Last Eda Gertrude Mizel	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (or unknown) <input checked="" type="checkbox"/> NO <input type="checkbox"/> (If yes, give date of discharge) KOREAN		
16b. SOCIAL SECURITY NO 038-18-4670		17. INFORMANT Eline Buckbinder Address 2804 Spind 1a		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>cerebral edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>subarachnoid hemorrhage</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days 5 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) apian death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Ruth K. Jakoby		22c. DATE SIGNED 5-18-69		22d. PHYSICIAN'S NAME (Type) Ruth K. Jakoby
23a. B. RIAL, CREMATION, REMOVAL (Specify) REMOVAL-BURIAL		23b. DATE 5-20-69		23c. NAME OF CEMETERY OR CREMATORY LINCOLN PARK CEMETERY
23d. LOCATION (City or Town) WARWICK, RHODE ISLAND		23e. REC'D BY REGISTRAR MAY 20 1969		23f. REGISTRAR'S SIGNATURE James J. Dodge
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1 68

07299										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07296									
1 DECEASED-NAME (Type or Print)										First Middle Last										2a. DATE KNOWN OF DEATH									
Thomas										Burgess										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> 5-4-69 192: 4:1am M 2c. DATE PRONOUNCED DEAD 5 Month 4 Day 69 Year 193:10am M									
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY							
Male		Negro		4-4-1937		32 YRS		MONTHS		DAYS		D. C.		U.S.A.		Prince George's		Electrician											
10 CITY OR TOWN OF DEATH										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12c. STREET AND NUMBER									
Cheverly										Prince George Hospital										662 Jefferson St. N.E.									
13a. USLA. RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN									
District Of Columbia										Washington										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										17. INFORMANT									
First Middle Last										First Middle Last										ADDRESS									
Dock										Burgess										Dock Burgess - 5909 7th Street, NW									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)										16b. SOCIAL SECURITY NO.										17. INFORMANT									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of right chest										minutes																			
765X																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)																			
										(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY Month, Day, Year HOUR A.M.										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
										2:40am 5-4- 19 69										Shot during altercation									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No City or Town County State									
										Glen Arden Town Hall, Glen Arden, Prince George's Co., Maryland																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										22b. DATE SIGNED									
EXAMINER'S NAME (Type)										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										5-5-69									
John Kehoe MD										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										ADDRESS (Street, city, town, or county)									
Riverdale, Md.																													
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY									
Burial										5-9-69										Harmony Memorial Park									
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
John T. Rhines Co. Funeral Home										MAY 8 1969										[Signature]									
3015 12th Street, N. E.																													

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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07300

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07297

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		Month		Day		Year		2b HOUR			
Kermit						Butler		5-28-69		19		10		30am					
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month		Day		2d HOUR			
Male	Negro	12-26-1920		48 YRS		MONTHS DAYS		HOURS MIN		5-28-69		19		10		30am			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH								Md			
Maryland		U.S.A.		WIDOWED		DIVORCED		Prince George's											
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY													
Rivendale		Leland Memorial Hospital																	
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		3d INSIDE CITY LIMITS?		13c STREET AND NUMBER													
Maryland		Prince George's		Banner		YES		NO		4533 Banner Street									
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last					
Unknown								Lucille ?											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or UNKNOWN)		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS											
						LUCILLE BARBOUR - MOTHER													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY:																hours			
IMMEDIATE CAUSE (a) Heart failure																			
DUE TO, OR AS A CONSEQUENCE OF Hypertensive arteriosclerotic heart disease																unknown			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
MEDICAL CERTIFICATE ON																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				YES				NO			
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH				21b TIME OF INJURY Month Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
				19 P.M.															
21d INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No				City or Town				County			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner																			
Autopsy, Inspection, Inquiry, and in my opinion																			
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				ASSISTANT MEDICAL EXAMINER				22b DATE SIGNED							
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER								5-28-69							
John Kehoe MD				Rivendale, Md.				ADDRESS (Street, city, town, or county)											
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town)				(County)			
Burial				6/2/1969				HARMONY				LANDOVER				MARYLAND			
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE							
W. ERNEST JARVIS JR.				1432 U.S. HIGHWAY				6 1969				Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07301

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07298

1. DECEASED NAME (Type or print)		First Agatha	Middle E.	Last Carpenter	2a. DATE OF DEATH Month May Day 8 Year 1969		2b. HOUR 2:00 P.M.	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 11/21/01		6. AGE (In years lost birthday) 67 YRS		7. FUNDING YEAR MONTHS 6 DAYS 19 HOURS 19 MIN
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md		
10. CITY OR TOWN OF DEATH Glenn Dale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Unknown - Retired		12b. KIND OF BUSINESS OR INDUSTRY --		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1909 Rosedale Street, N.E.
14. FATHER'S NAME First Robert Middle Jackson Last Rose		15. MOTHER'S MAIDEN NAME First Rose Middle Chapman Last Chapman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) <input checked="" type="checkbox"/> No		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Decedent Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aspiration pneumonia 4369 DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent cerebrovascular accidents Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Generalized arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours years years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic glomerulonephritis								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that the (this hospital) attended the deceased from 11/21/ 1968 , to 5/8/ 1969 , that the (we) last saw the deceased alive on 5/8/ 1969 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) not view the body after death.								
22b. SIGNATURE Moe Weiss				22c. DATE SIGNED 5/8/69				
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 5-12-1969		23b. DATE 5-12-1969		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVE		23d. LOCATION (City or Town) (County) (State) WASHINGTON D.C.		
24. FUNERAL DIRECTOR W. E. HARRIS Co.				ADDRESS 1432 You St. N.W.		25a. RECD BY REGISTRAR MAY 14 1969		25b. REGISTRAR'S SIGNATURE



4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
07302 CERTIFICATE OF DEATH 07299											
1. DECEASED NAME (Type or print)			First Lula		Middle B.		Last Carter		2a. DATE OF DEATH Month 5 / Day 19 / Year 69		
3 SEX F			4. RACE N		5. DATE OF BIRTH 6/15/96		6. AGE (In years last birthday) 72 YRS.		2b. HOUR 5:30P M		
7a. BIRTHPLACE (State or foreign country) Va.			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges, Md.				
10. CITY OR TOWN OF DEATH Glenn Dale			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) retired			12b. KIND OF BUSINESS OR INDUSTRY unknown		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Va.			13b. COUNTY Washington, D.C.		13c. CITY OR TOWN Washington, D.C.		3d. INS OF CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1165 3rd St., N. E.		
14. FATHER'S NAME First Charles Middle Burger Last Burger			15. MOTHER'S MAIDEN NAME First Mamie Middle Coles Last Coles								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 579-44-7875		17. INFORMANT decendent Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction										3 days	
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerosis										years	
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis										years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month 19 Day 19 Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/20/19 67 , to 5/19/19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/19/69 19 69 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Moe Weiss						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/19/69			
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.						22e. ADDRESS Glenn Dale Hospital, Glenn Dale, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 5-23-69		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Ft. Myer, Arlington, Va.		23d. LOCATION (City or Town) (County) (State)				
24. FUNERAL DIRECTOR Hall Bros. - N.W. Wash. D.C.			ADDRESS 621-7th St. N.W.			25a. REC'D BY REGISTRAR MAY 22 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE/
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 23 Film 413 6/9/69 kk 07303										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07300														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																		
1. DECEASED NAME (Type or Print)					First Middle Last					2a. DATE KNOWN OF DEATH					Month Day Year					2b. HOUR														
William					L					Cashion					5-20-69					1910:00am														
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS		2c. DATE PRONOUNCED DEAD					2d. HOUR																	
Male		White		9-2-1924		44 YRS		MONTHS		DAYS		Month Day Year					2d. HOUR																	
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH					Md														
Virginia					USA										Prince George's																			
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY																			
Cheverly					Prince George Hospital																													
13a. USUAL RESIDENCE (Where deceased lived, if institution on residence before admission) STATE					13b. CITY OR TOWN					13c. INSIDE CITY LIMITS?					13e. STREET AND NUMBER																			
Virginia					Chesterfield					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					9620 Jefferson Davis Hgway.																			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																													
Herbert R. Cashion					Vada										Holmes																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO					17. INFORMANT					ADDRESS																			
No																																		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I DEATH WAS CAUSED BY:																																		
IMMEDIATE CAUSE (a) Drowning																																		
DUE TO, OR AS A CONSEQUENCE OF																																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																																		
(b)																																		
DUE TO, OR AS A CONSEQUENCE OF																																		
(c)																																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																		
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?														
																				YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH										21b. TIME OF INJURY Month, Day, Year										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
										10:00am 5-20-69										undetermined														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or RFD No City or Town County State														
										Anacostia river, Bladensburg, Prince George County, Maryland																								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>																																		
ACTUAL SIGNATURE										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										22b. DATE SIGNED														
EXAMINER'S NAME (Type)										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										5-26-69														
John Kehoe MD										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																								
Riverdale, Md.										ADDRESS (Street city town or county)																								
23a. BURIAL CREMATION OR REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)				
Burial										5/28/1969										Mt. Calvary Cemetery										Richmond, Virginia				
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE														
C. M. Travel										JUN 2 1969										Charles Judge														
Falls Church Funeral Home,																																		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form "PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6 Film 113
5/29/69 kk
Iters 2a, Film 113 6
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07301

1 DECEASED NAME (Type of name) 07304 Moses			First Middle Last Cattman			2a DATE KNOWN OF EST. DEATH MAY 15 1969			2b HOUR 9:00 M						
3 SEX Male		4 RACE Negro		5 DATE OF BIRTH 5-8-21		6 AGE (In years) 48 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c DATE PRONOUNCED DEAD Month 5-15- Year 1969		2d HOUR 11:00 M			
7a BIRTHPLACE (State or foreign country) U.S.A.				7b CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. COUNTY OF DEATH Prince George's			
10 CITY OR TOWN OF DEATH Bladensburg				11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) DICK PRINCE GEN HOSP.				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) N/A				12b KIND OF BUSINESS OR INDUSTRY N/A			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.				13b COUNTY Prince Geo. Brentwood				13c CITY OR TOWN YES <input type="checkbox"/> NO <input type="checkbox"/>				13d INSIDE CITY LIMITS? 4519 41st Street			
14 FATHER'S NAME unk				15. MOTHER'S MAIDEN NAME unk				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b SOCIAL SECURITY NO 145-28-8350			
17. INFORMANT none				ADDRESS											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Advanced nutritional cirrhosis of liver DUE TO, OR AS A CONSEQUENCE OF (c) Edema and congestion of lungs												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or RFD No City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Victor A. Fazekas				M.D. Acting Victor A. Fazekas, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b DATE SIGNED 5-17-69			
23a BURIAL CREMATION ON REMOVAL (Specify)				23b DATE 5-21-69				23c NAME OF CEMETERY OR CREMATORY Lincoln Mem.				23d LOCATION (City or Town) (County) (State) Spitland Rd Md			
24 FUNERAL DIRECTOR H. S. Washington				ADDRESS 5003 4925 Drane Ave				25a REC'D BY REGISTRAR MAY 23 1969				25b REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MAY 18 & 20 1969										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07305										07304									
1 DECEASED-NAME (Type or print)										2a DATE OF DEATH									
Irene Chivis										May 4 Day Year 69									
3 SEX										2b HOUR									
Female										10:55									
4 RACE										5 DATE OF BIRTH									
Colored										09-08-17									
7a BIRTHPLACE (State or foreign country)										6 AGE (In years lost birthday)									
Maryland										51 YRS.									
7b CITIZEN OF WHAT COUNTRY?										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
U.S.A.										9. COUNTY OF DEATH									
Prince George										Md									
10 CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)									
Cheverly										Prince George General									
12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b KIND OF BUSINESS OR INDUSTRY									
13a USUAL RESIDENCE (Where deceased lived if institution- Residence before admission) STATE										13c CITY OR TOWN									
Maryland										Laurel									
13b COUNTY										13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>									
Prince Geo.										Box 405 Grant Ave.									
14. FATHER'S NAME First Middle Last										15. MOTHER'S MAIDEN NAME First Middle Last									
George Brooks										Priscilla Caren									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO									
										17 INFORMANT Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u>																			
1519 DUE TO, OR AS A CONSEQUENCE OF										abt 6 months									
(b) <u>Adenocarcinoma of the stomach</u>																			
(c) <u>(Linitis Plastica)</u>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
5/3/69																			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19									
21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)									
21f LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																			
22b SIGNATURE										22c DATE SIGNED									
Felix Flores										5/4/69									
22d PHYSICIAN'S NAME (Type)										22e ADDRESS									
FELIX FLORES																			
23a BURIAL, CREMATION, REMOVA (Specify)										23b DATE									
BURIAL										5/9/69									
23c NAME OF CEMETERY OR CREMATORY										23d LOCATION (City or Town) (County) (State)									
CARVER MEMORIAL PARK										LAUREL Md.									
24 FUNERAL DIRECTOR										25a REC'D BY REGISTRAR									
Robert L. Snowden										8 1969									
25b REGISTRAR'S SIGNATURE																			
Rockville, Md.																			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1519
45M - 1

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
07306									
07303									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Paul			Cocchiaro			May Day 14, 1969			2 P. M.
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER YEAR	
Male		White		10-21-78		70 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Italy			USA				Prince Georges Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Riverdale			Eugene Leland Memorial Hosp.			COAL-MINER			
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.			Prince Georges		Bladensburg				5405 Tilden Road
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Ignatius			Cocchiaro			Giovanni Belliziere			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				
NO			577124026A		daughter/Medical Record				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)									
4109									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b) Myocardial infarction						
			(c) Arteriosclerosis						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			HOUR A.M. Month Day Year P.M.						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME - FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from 5-7, 1969, to 5-14, 1969, that (I) (we) last saw the deceased alive on 5-14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE			22c. DATE SIGNED						
D. R. Purdie, M.D.									
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
D. R. PURDIE, M.D.			RIVERDALE, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL			5-17-1969		FORT LINCOLN CEM.		COLMAR MANOR, MD		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
W. W. CHAMBERS CO. RIVERDALE, MD			MAY 19 1969						

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07307

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07304

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			Month Day Year			2b HOUR			
Lleulllyn			Cofield			5			9 19 69			8:45 PM			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	2c DATE PRONOUNCED DEAD			Month Day Year			2d HOUR			
M	Negro	3 Nov 1968	YRS 5	MONTHS 5	DAYS 6	5			9 19 69			8:45 PM			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			Md.			
Pa.			USA						Prince George						
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY						
Cheverly			Prince George Hosp												
13a USUA. RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e. STREET AND NUMBER			
Md.			Prince George Hyattsville			LeYES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						7290-B 79th Ave.			
14 FATHER'S NAME			15. MOTHER'S M.A.DEN NAME												
First Middle Last			First Middle Last												
Henry Cofield			Diane Franklin												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
						Henry Cofield, Hyattsville, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Cerebral concussion															
DUE TO, OR AS A CONSEQUENCE OF Skull fracture 11cm															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause															
(b) DUE TO, OR AS A CONSEQUENCE OF Trauma												5 hrs.			
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b TIME OF INJURY Month, Day, Year						21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
						3:05 PM 5 9 19 69						Fell off bed			
22. INJURY OCCURRED						21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f LOCATION Street or R.F.D. No City or Town County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						Bedroom						7290-B 79th Ave., Hyattsville P.G. Md.			
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b DATE SIGNED			
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						5-10-69			
John Kehoe, M.D., Riverdale						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
						ADDRESS (Street, city, town, or county)									
23a BURIAL, CREMATION, REMOVAL (Specify)						23b DATE						23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial						5/12/69						Douglas Cemetery		Alexandria, Va.	
24. FUNERAL DIRECTOR						ADDRESS						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Greene Funeral Home, Alexandria, Va.												MAY 13 1969		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
FRANK			CONNOLLY			MAY 11 1969			2:15PM				
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
MALE		CAUCASIAN		1-2-1885		84 YRS		MONTHS DAYS		HOURS MIN.			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
New York			USA						PRINCE GEORGES Md.				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Forestville			Regent Nursing Home			Wife Lathie Foreman							
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INS DE CITY, JAN 1957		13e STREET AND NUMBER			
Md.			Prince Georges Forest Hts			YES <input type="checkbox"/> NO <input type="checkbox"/>				341 Huron Dr			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
Unknown			Unknown										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
no						Maria Connolly, Wife			341 Huron Drive, S.E., Forest Hill, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest.													
4. DUE TO, OR AS A CONSEQUENCE OF Myocardial infarction													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
Diabetes Pneumonia - Urinary tract infection													
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
		HOUR A.M. Month Day Year											
		P.M. 19											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State								
22a I certify that (I) (this hospital) attended the deceased from 5-1-1969, to 5-11-1969, that (I) (we) last saw the deceased alive on 5-9-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE			DEGREE			ATTENDING PHYS.			MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED	
Oliver B. Bond			MD									5-12-69	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS										
OLIVER B. BOND MD			7420 MARLBORO PIKE FORESTVILLE MARYLAND 20028										
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial		5/16/69		St. Marys Cemetery			Grassmere, Staten Island, NY						
24. FUNERAL DIRECTOR Robert E. Wilhel, Funeral Home						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
4308 Suitland Rd., S.E., Suitland, Md., 20023						MAY 15 1969			[Signature]				

7639

1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07309 Item 23 Film 413 6/18/69 kk		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		08778	
1 DECEASED NAME (Type or print) First Middle Last BELINDA ALSTON CORDELL			2a. DATE OF DEATH Month MAY Day 26 Year 69		2b. HOUR P 1023
3 SEX Female	4 RACE Negro	5 DATE OF BIRTH 26 May 1969		6 AGE (in years last birthday) 5 YRS.	IF UNDER 1 YEAR MONTHS 5
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md
10. CITY OR TOWN OF DEATH Camp Springs		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Malcolm Grow USAF Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
13a U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland		13b COUNTY Prince George's	13c CITY OR TOWN Suitland	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 3807 Swann Road, Apt. 202
14 FATHER'S NAME First Middle Last MC GRADY CORDELL		15 MOTHER'S MAIDEN NAME First Middle Last ISABEL ALSTON			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b SOCIAL SECURITY NO		17 INFORMANT McGrady Cordell, 3807 Swann Rd Suitland, Md	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia 1639 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Maternal Amnionitis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Hrs 5 Hrs 1 Day
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Prematurity					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2 Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No City or Town County State	
22a. I certify that (I) the hospital attended the deceased from 26 May , 19 69 , to 26 May , 19 69 , that (I) was lost saw the deceased alive on 26 May , 19 69 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death.					
22b SIGNATURE Richard F. Dodds MD		22c DATE SIGNED 26 May 69		22d PHYSICIAN'S NAME (Type) RICHARD W. DODDS,	
22e ADDRESS Malcolm Grow USAF Hospital Andrews AFB Md		23a BURIAL (CREMATION) REMOVAL (Specify) 6/13/69			
23b DATE		23c NAME OF CEMETERY OR CREMATORY FEDERAL		23d LOCATION (City or Town) (County) (State) Washington D.C.	
24. FUNERAL DIRECTOR Carl F. Oupert		25a. REC'D BY REG STRAR DATE JUN 12 1969		25b REGISTRAR'S SIGNATURE Charles J. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4123

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First Hardie		Middle Council		Last Council		2a. DATE OF DEATH Month May Day 15 Year 1969		2b. HOUR 1:35 A. M.
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 5/24/1906		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges				MD
10. CITY OR TOWN OF DEATH Glenn Dale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Unknown		12b. KIND OF BUSINESS OR INDUSTRY --				
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE D.C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1412 Massachusetts Ave. S.E.		
14. FATHER'S NAME First Min Middle Council Last Council		15. MOTHER'S MAIDEN NAME First Ann Middle E. Last Jenkins								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 578-16-9183		17. INFORMANT Decedent						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism, multiple										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) Arteriosclerotic heart disease										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Arteriosclerotic heart disease										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebrovascular accident; generalized arteriosclerosis; probable pulmonary tuberculosis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour AM Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from 4/25/1969 , to 5/15/1969 , that (X) (we) last saw the deceased alive on 5/15/1969 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.										
22b. SIGNATURE Moe Weiss		DEGREE M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5/15/69				
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/20/69		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION (City or Town) (County) (State) Maryland				
24. FUNERAL DIRECTOR Stewart		ADDRESS Funeral Home-4001 Benning Road		25a. REC'D BY REGISTRAR MAY 20 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07311

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

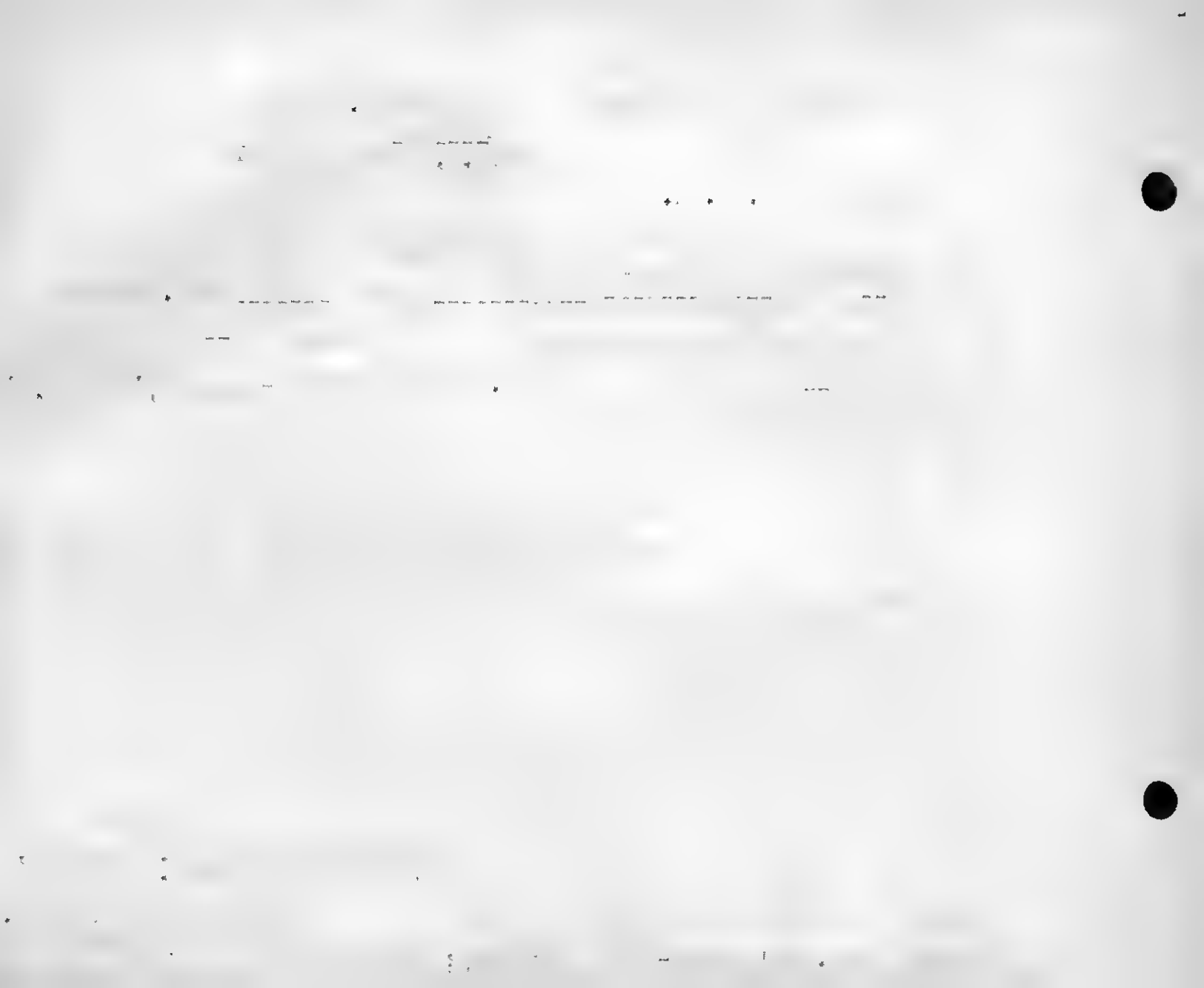
07307

1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR
LeRoy				Craig	MATED		5	4	69	191:25am M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c DATE PRONOUNCED DEAD		Month	Day	Year
Male	White	2-6-1902	67 YRS			5		4	69	191:32am M
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Ohio		U. S. A.				Prince George's				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Cheverly		Prince George Hospital		Ret. Inspector		Carbide Co.				
13a USUAL RESIDENCE (Where deceased lived, if not on residence before death)		13b. COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Maryland		Prince George's		Lanham		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5634 Whitfield Chapel Rd.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Robert				Craig	Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
Unknown						Margaret Craig		Glen Freeis, W. Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes over 3 mo.										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b. DATE SIGNED						
John Kehoe		John Kehoe MD Riverdale, Md.		5-5-69						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATOR		23d. LOCATION (City or Town)		(County)		(State)
Burial		5/7/69		Montgomery Mem. Park		London		Kanawha		W. Va.
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Francis Gasch's Sons Hyattsville, Maryland						MAY 7 1969		H. Leonard Jones		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Wesley		Middle Warren		Last Cromwell, Sr.		2a. DATE OF DEATH Month May Day 22 , Year 1969		
3 SEX Male		4. RACE White		5. DATE OF BIRTH Nov. 2, 1897			6 AGE (In years last birthday) 71 YRS.		2b HOUR 9 P M		
7a BIRTHPLACE (State or foreign country) Minnesota		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md					
10. CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George's Gen. Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Cattle Ranch Farm			12b KIND OF BUSINESS OR INDUSTRY Own Ranch		
13a USUAL RESIDENCE (Where deceased lived, if institution: Res. date before adm. ssion) STATE Montana		13b COUNTY Daniels		13c CITY OR TOWN Scobey		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Box 351 Gen. Delivery			
4. FATHER'S NAME First Charles Middle Fremont Last Cromwell			15 MOTHER'S MAIDEN NAME First Lennie Middle -- Last Ward								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No			16b SOCIAL SECURITY NO --			17 INFORMANT Mrs. Myrtle Cromwell- Scobey, Montana.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) C. V. A 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Generalized Arteriosclerotic disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (X) this hospital attended the deceased from May 17 , 19 69 , to May 22 , 19 69 , that (I) (we) last saw the deceased alive on May 22 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Rene Gomez			DEGREE RENE GOMEZ		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c DATE SIGNED 5/23/69			
22d. PHYSICIAN'S NAME (Type) RENE GOMEZ			22e ADDRESS Prince Georges Gen. Hospital, Cheverly, Maryland.								
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 5/27/69		23c NAME OF CEMETERY OR CREMATORY Scobey Cemetery			23d. LOCATION (City or Town) (County) (State) Scobey- Daniels-Mont.			
24 FUNERAL DIRECTOR Ritchie Bros. Fun'l Home			ADDRESS Upper Marlboro, Maryland 20870			25a REC'D BY REGISTRAR MAY 29 1969		25b REGISTRAR'S SIGNATURE [Signature]			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 10. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07313		07309											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																							
1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR							
Ethel		K		Curtis				5-29		1969				8:30		P.M.							
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER YEAR		8. UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month		Day		Year		2d. HOUR					
F	W	9 Sept 1914		54 YRS		MONTHS		DAYS		5		29		1969		9:06		P.M.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH																	
Ohio		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George																	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY																	
Clinton, Maryland		Clinton Hospital		Sears																			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		13f. RD.													
Va. Md.		Arlington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4414 North Carlyn Spring																	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last									
Albert		Rich		Gladys		Jarrett																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS		4414 Carlyn Springs Rd.		Arlington, Virginia													
		577-01-6868		Benjamin H. Curtis																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										Heart failure		Min.											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Arteriosclerotic heart disease		unknown											
(c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
										19													
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21c. LOCATION Street or RFD No		City or Town		County		State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE										CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		5-30-69					
EXAMINER'S NAME (Type)										John Kehoe, M.D., Riverdale		ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)					
Burial										June 2, 1969		Mt. Holly Cemetery		Remington, Virginia									
24. FUNERAL DIRECTOR										ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Ives Funeral Home										2847 Wilson Boulevard		JUN 5 1969											
Arlington, Virginia																							



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

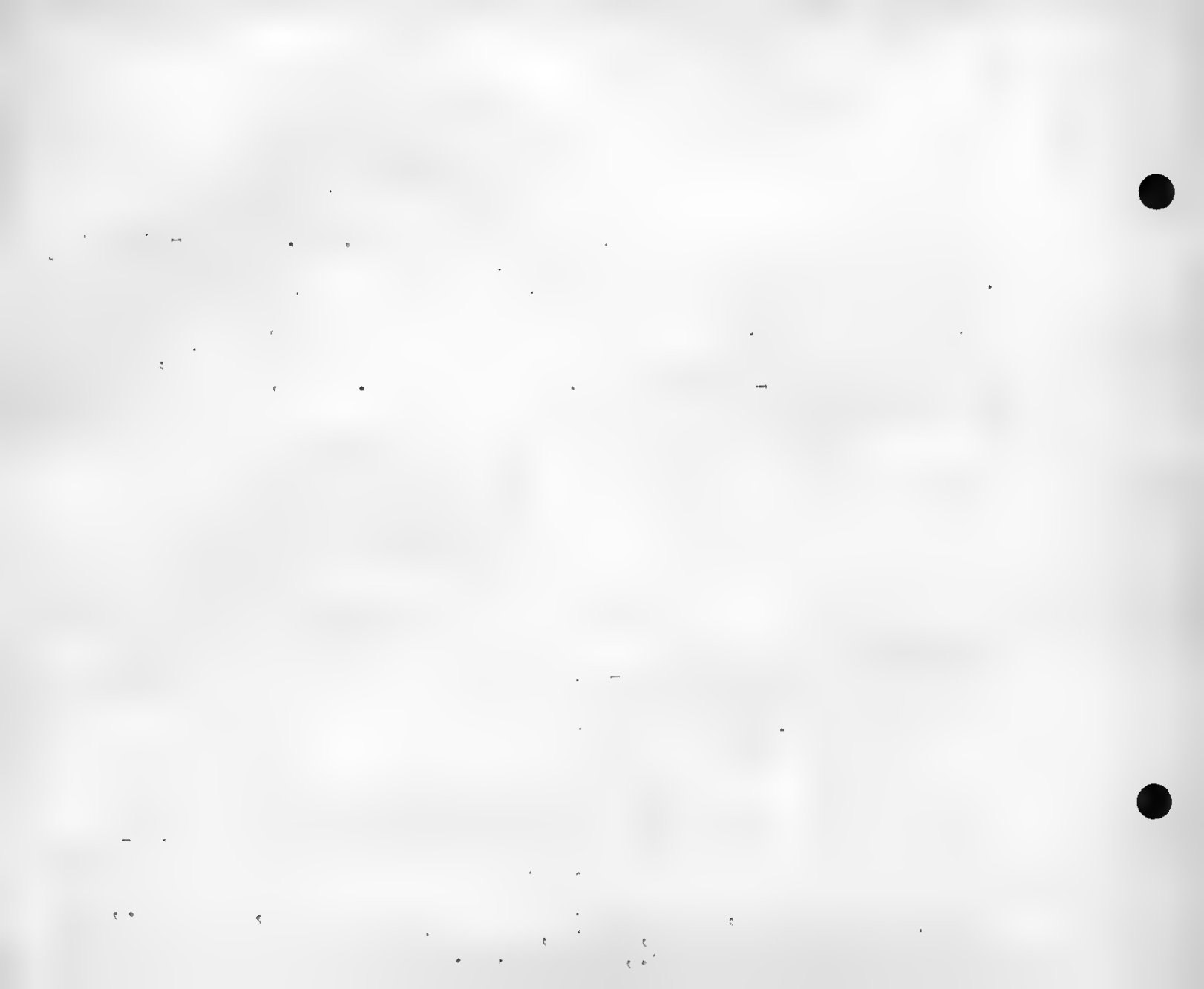
07314

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07310

1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
William Maurice Davis						5-20-69			1912:31am					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR			
Male	White	10-7-1922	46 YRS	MONTHS	DAYS	HOURS	MIN	5 Month 20 Day 69 Year			1912:50am			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH					
Oklahoma			USA						Prince George's			Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. SLA. OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly			Prince George Hospital			Asst. Reg. Manager-Boiler Manuf								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS			13d. STREET AND NUMBER			13e. ACTURE		
OHIO			PRINCE GEORGE'S			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			100 JACKSON DRIVE					
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
William Earl Davis			Janette Sanders											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT								
Yes 3/1945-10/1945			Yes.			Ruth P. Davis, 100 Jackson Drive								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Transection of spinal cord at C-7-T-1</u>														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														
(b) <u>and Bilateral hemothorax</u>														
DUE TO OR AS A CONSEQUENCE OF														
<u>Multiple rib fractures</u>														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)						
				12:30am 5-20-1969				Occupant of car involved in collision						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or RFD No City or Town County State						
				Rt. 495 near Rt 274, Prince George County, Maryland										
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED						
<u>John Kehoe MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				5-21-69						
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)						
Rivardale, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)								
Burial		May 24, 1969		Hominy City Cemetery		Hominy, Osage Co., Oklahoma								
Jack Powell Funeral Home, Hominy, Oklahoma		AREHART FUNERAL HOME INC., La Plata, Md.		MAY 26 1969		RECD BY REGISTRAR		25a. REGISTRAR'S SIGNATURE						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
RENATO SILVINO DEL PINO						✓ Month 4 Day 69 Year		1230 PM		
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR		
Male		White		2-17-22		47 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
CUBA		CUBA				Prince George Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George General Hospital			CIVIL ENGINEER				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Prince George		Lanham		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5417 85th Ave. Apt. 1	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
JUAN M. DEL PINO			CELIA PEREZ							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO			220-50-7816		Marie Renato		5417 85th AVE APT #1 SOME LANHAM, MD.			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY.										
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION										
DUE TO, OR AS A CONSEQUENCE OF										
(b) ATHEROSCLEROTIC HEART DISEASE										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 HOUR										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		Hour A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION					
Where <input type="checkbox"/> Not where <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 19 68, to MAY 19 69, that (I) (we) last saw the deceased alive on APRIL 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					22c. DATE SIGNED					
Fidel J. Quintana					✓ 4-69					
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
FIDEL J. QUINTANA					8715 FIRST AVE, S. SPRING, MD.					
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		MAY 7, 1969		FORT LINCOLN CEM.		COMAR MANOR, PRINCE GEORGES CO., MD.				
24. FUNERAL DIRECTOR					25a. REC'D BY REG. STRA		25b. DATE			
W. W. CHAMBERS Co.					RIVERDALE, MD.		MAY 8 1969			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07316

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07312

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH			<input type="checkbox"/> Month	<input type="checkbox"/> Day	<input type="checkbox"/> Year	2b HOUR
Richard Elzzie Dement						5 29 19 69						5:10 PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR	
Male	W	May 19, 1892	77 YRS	MONTHS		DAYS		Month 5 Day 29 Year 19 69			5:25 PM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH						
Md.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George		Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY			
Cheverly			Prince George Hosp.			Farming			Tobacco			
13a USUAL RESIDENCE (Where deceased lived, if not in hospital admiss on) STATE			13b CITY OR TOWN		13c INSIDE CITY LIMITS?		13e STREET AND NUMBER					
Md.			Prince George		Clinton		YES <input type="checkbox"/> NO <input type="checkbox"/>			7838 Den Lee Drive.		
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last	
James E. Dement						Sara V. Jenkins						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT			9411 Jackson Ave.				
No			217-36-6922		Richard Dement			Ft. Wash., Forrest, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											Min.	
Heart failure												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b)												
Arteriosclerotic heart disease unknown												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b)												
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?		
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
			HOUR A M. P M. 19									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED			
<i>John Kehoe</i>			John Kehoe, M.D., Riverdale			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			5-30-69			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town)		(County) (State)		
Burial			6-2-69		Resurrection			Clinton, Pr. Geo. Md.				
24 FUNERAL DIRECTOR			Hunt Funeral Home Waldorf, Md.			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
						DATE JUN 9 1969			<i>W. Charles Jones</i>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-43, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 6&24 Filr 3413
6/9/69 kk
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #23b, Film Gl 13 6/11/69

07313

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) 07317 Helen Lydia DiFrancesco		First Middle Last		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 5 31 1969		2b. HOUR 6:00 AM	
3 SEX F	4 RACE W	5. DATE OF BIRTH 14 Dec., 1912	6 AGE (in years last birthday) 56	7. MONTHS 5 YEARS 31	2c. DATE PRONOUNCED DEAD Month 5 Day 31 Year 1969		2d. HOUR 12:16 PM
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George Md	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Prince George		13c. CITY OR TOWN Hillside, Md		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last GEORGE T. DUDLEY		15. MOTHER'S MAIDEN NAME First Middle Last CHARLES LAVENIA WOODBRIDGE		13e. STREET AND NUMBER 5290 Marlboro Pike			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO 237-22-4048		17. INFORMANT ADDRESS Frank J. DiFrancesco 5290 Marlboro Pike Hillside, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 41.9 DUE TO, OR AS A CONSEQUENCE OF Coronary artery occlusion days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease yrs. (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year 19 HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type)		M.D. John Kehoe, M.D., Riverdale		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-1-69	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE June 3, 1969		23c. NAME OF CEMETERY OR CREMATORY MARY CEMETERY		23d. LOCATION (City or Town) (County) (State) Richmond, VA	
24. FUNERAL DIRECTOR Joseph W. Bailey		ADDRESS Funeral Home, Richmond, Va.		25a. REG'D BY REGISTRAR DATE JUN 5 1969		25b. REGISTRAR'S SIGNATURE Richard Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

07318										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07314																																							
1 DECEASED-NAME (Type or print)										2a DATE OF DEATH										2b HOUR																																							
Velma F. Dillman										May 16 1969										11:40PM																																							
3 SEX Female										4 RACE White										5 DATE OF BIRTH 2/24/17										6 AGE (In years last birthday) 52 YRS										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 MRS. HOURS MIN									
7a BIRTHPLACE (State or foreign country) N. C.										7b CITIZEN OF WHAT COUNTRY? U. S. A.										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH Prince George's Md																													
10 CITY OR TOWN OF DEATH Cheverly										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife										12b KIND OF BUSINESS OR INDUSTRY Own Home																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. COUNTY Prince George's										13c. CITY OR TOWN College Park										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e STREET AND NUMBER 4805 Delaware St.																			
14. FATHER'S NAME First Middle Last James Henry Dillman										15. MOTHER'S MAIDEN NAME First Middle Last Florence High										16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. none										17 INFORMANT Address Mr. Jesse E. Dillman Same as #13																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Ca to lungs & Vertebral C-7										DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of St. Breasts										DUE TO, OR AS A CONSEQUENCE OF (c) 5 years																													
Conditions, if any which gave rise to immediate cause (a) stating the underlying cause last.																																																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)										21f. LOCATION Street or R.F.D. No City or Town County State																																							
22a. I certify that (I) (the hospital) attended the deceased from May 16, 1969, to May 16, 1969, that (I) (we) lost saw the deceased alive on May 16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (do not) view the body after death.																																																											
22b. SIGNATURE William C. Weintraub										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 5/17/69																																							
22d. PHYSICIAN'S NAME (Type) William C. Weintraub, M.D.										22e. ADDRESS Professional Bldg., Greenbelt, Md. 20770																																																	
23a. BURIAL, CREMATION, REMOVA. (Specify) Burial										23b. DATE 5/20/69										23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln										23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.																													
24. FUNERAL DIRECTOR Francis Gasch's Sons										ADDRESS Hyattsville, Md.										25a. REC'D BY REGISTRAR MAY 20 1969										25b. REGISTRAR'S SIGNATURE Charles Under																													

1707

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>07319</div> <div>CERTIFICATE OF DEATH</div> <div>07315</div>									
1 DECEASED NAME (Type or print) DAWN M DINGELDEIN					2a DATE OF DEATH MAY Month 27 Day 69 Year			2b HOUR a 5:50 M	
3 SEX FEMALE		4 RACE CAUCASIAN White		5. DATE OF BIRTH 14 Oct 53		6 AGE (In years last birthday) 15 YRS		IF UNDER 1 YEAR MONTHS DAYS 	
7a BIRTHPLACE (State or foreign country) MICH		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE Md			
10 CITY OR TOWN OF DEATH ANDREWS AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MALCOLM GROW USAFHOSP				12a. USUAL OCCUPATION (Kind of work done during months preceding death, even if retired) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY Public Schools	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MARYLAND		13b. COUNTY PRINCE GEORGE		13c. CITY OR TOWN ANDREWS AFB		13d. INSIDE CITY LHM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3845 MICHIGAN AVE	
14 FATHER'S NAME First Middle Last CURTIS FRED DINGELDEIN				15 MOTHER'S MAIDEN NAME First Middle Last JOYCE MARY MICHAUD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. --		17 INFORMANT Address FATHER SAME AS ITEM #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1709 METASTASIS TO LUNG								5 Months	
DUE TO, OR AS A CONSEQUENCE OF (b) OSTEOGENIC CARCINOMA								14 Months	
DUE TO, OR AS A CONSEQUENCE OF (c) 									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that he (this hospital) attended the deceased from 21 May , 19 69 , to 27 May , 19 69 , that he (we) lost the deceased alive on 27 May , 19 69 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. He (we) did (did not) view the body after death									
22b. SIGNATURE <i>Jeffrey A. Graham</i> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>					22c. DATE SIGNED 27 May 69				
22d. PHYSICIAN'S NAME JEFFREY A GRAHAM CAPT USAF MC					22e. ADDRESS MALCOLM GROW USAFHOSP ANDREWS AFB				
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 5/30/69		23c. NAME OF CEMETERY OR CREMATORY Mikado Cemetery			23d. LOCATION (City or Town) (County) (State) Michiga		
24. FUNERAL DIRECTOR ADDRESS Ritchie Bros. Upper Marlboro, Md.					25a. REC'D BY REGISTRAR MAY 25 1969		25b. REGISTRAR'S SIGNATURE <i>Jeffrey A. Graham</i>		

07320

CERTIFICATE OF DEATH

07316

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1, Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Pn. Geo</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>FOREST HEIGHTS</i>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>FOREST HEIGHTS</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>103- Seneca Dr SE</i>		d. STREET ADDRESS <i>103- Seneca Dr SE</i>	
3 NAME OF DECEASED (Type or print) First <i>Archiebald</i> Middle <i>Vincent</i> Last <i>Dixon</i>		4. DATE OF DEATH Month <i>MAY</i> Day <i>6th</i> Year <i>1969</i>	
5 SEX <i>Male</i>	6 COLOR OR RACE <i>white</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>MAR. 21-1899</i>
9 AGE (In years last birthday) <i>70</i> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retd DC. Police - Dept.</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>INDUSTRY</i>		11 BIRTHPLACE (County & State, or foreign country) <i>MARYLAND</i>	
12 CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Samuel Dixon</i>	
14. MOTHER'S MAIDEN NAME <i>Mamie White</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <i>No</i>	
16 SOCIAL SECURITY NO <i>217-36-6344</i>		17. INFORMANT <i>Virgie M. Dixon - Wife - SAME AS Item #2</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4109</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	
20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>61</i> , to <i>May 6</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Jan 15</i> , 19 <i>61</i> , and that death occurred at <i>5 A</i> M, from causes on and on the date stated above.	
22a. SIGNATURE <i>Frank J. Talbot</i>		22b. DATE SIGNED <i>5/16/69</i>	
22c. PHYSICIAN'S NAME (Type) <i>Frank J. Talbot MD</i>		22d. ADDRESS <i>4273 Branch Ave SE Marlow Heights Md</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5-9-1969</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR <i>Simmons Bros.</i>		25a. REC'D BY REGISTRAR <i>MAY 8 1969</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. ADDRESS <i>1661-Good Hope Rd SE Wash</i>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

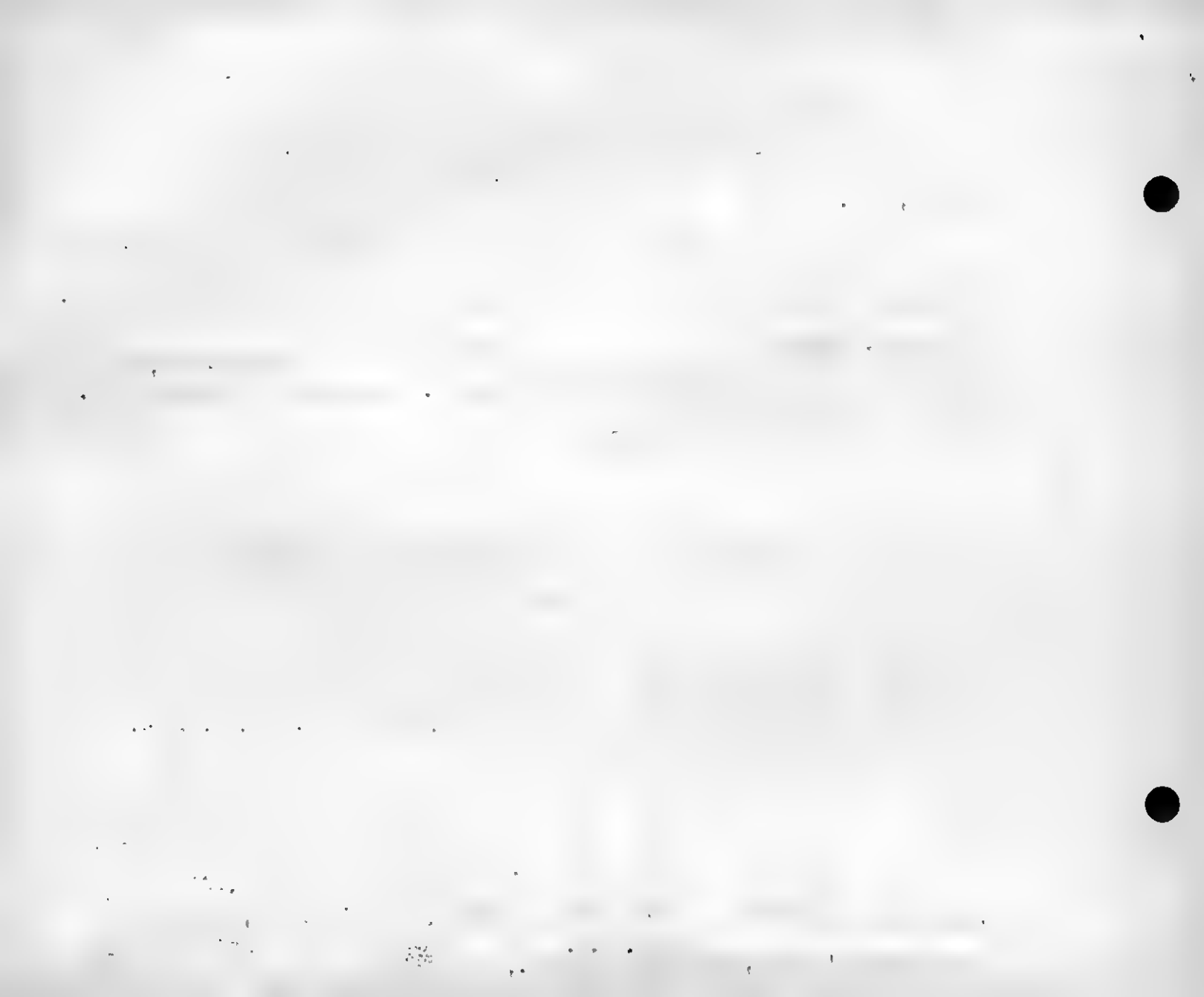
07321

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07317

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			Month Day Year			2b HOUR					
William			O			Dobbins			5-17-69			10:05am					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS		7c DATE PRONOUNCED DEAD		2d HOUR					
Male		White		7-9-1908		60 YRS				5-17-69		11:11am					
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH					
Selma, Ala.				USA								Prince George's Md					
10. CITY OR TOWN OF DEATH						11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a USA. OCCUPATION (Kind of work done during most of working life even if retired.)					
Cheverly						Prince George Hospital						Engineer					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE						13b. COUNTY						13c. CITY OR TOWN					
Maryland						Pr. Geo.						Silver Spring					
14 FATHER'S NAME						15. MOTHER'S MAIDEN NAME						13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					
William O. Dobbins						Mary Cothran						9203 New Hampshire Ave.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO.						17. INFORMANT					
no						420 34 0527						Cherry Chase, MD William O. Dobbins III 3553 Hamlet Pl.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Total injuries</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																	
DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)									
				10:05am 5-17-19 69				Struck by train									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No				City or Town					
				Glen Dale Crossing near				Duvall Rd., Glen Dale, Md. P.G. Co.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE				EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
<i>John Kehoe</i>				John Kehoe MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				5-18-69					
23a. B. RIAL CREMATION REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Cremation				5/20/69				Cedar Hill Crematory				Suitland, Maryland					
24. FUNERAL DIRECTOR				Wash. D.C.				25a. REC'D BY REG. STRAR				25b. REGISTRAR'S SIGNATURE					
Joseph Gawler's Sons, 5130 Wisconsin Av., NW								MAY 23 1969				<i>Charles Judge</i>					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

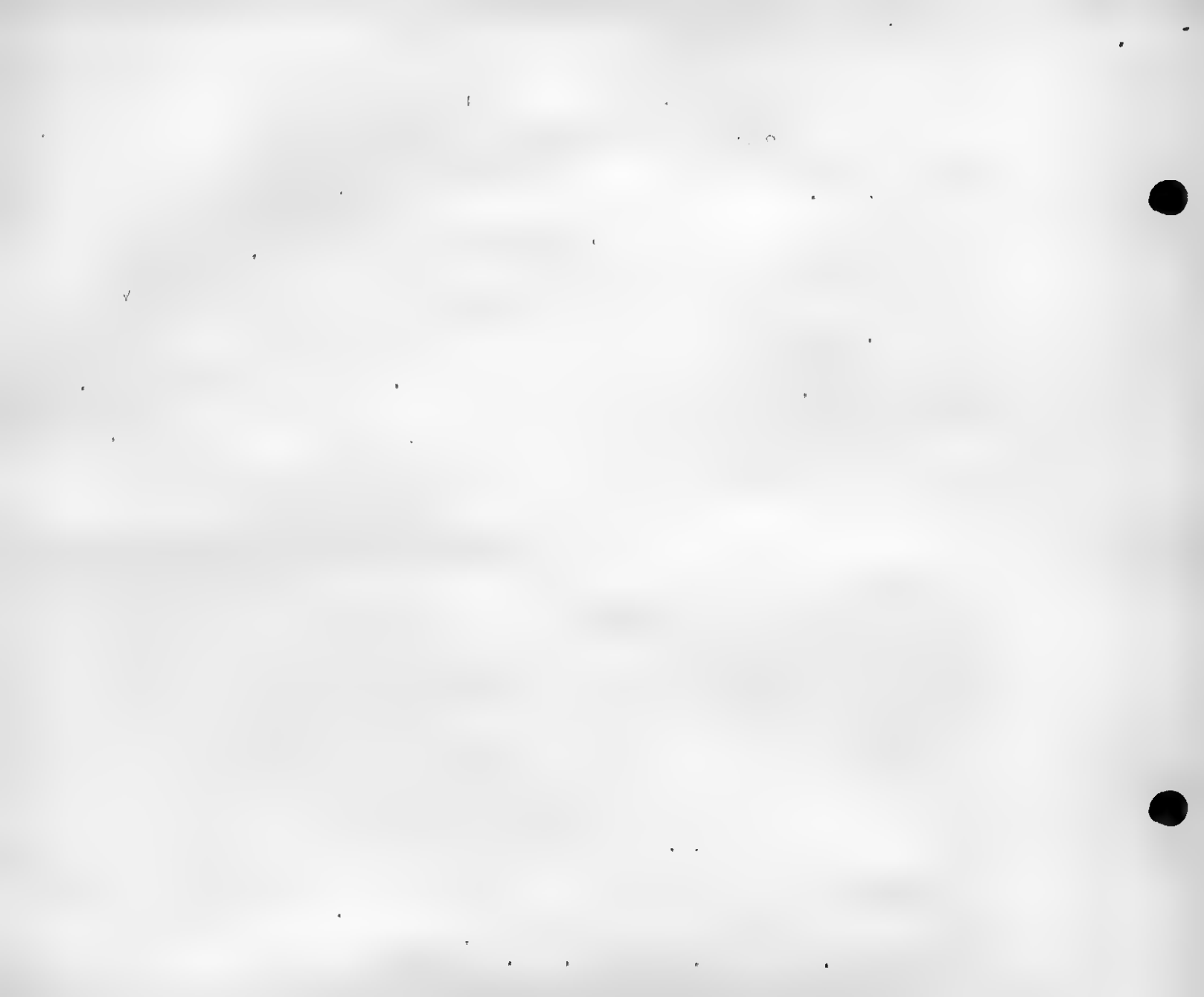
07322

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07318

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 5 10 69		2b. DATE PRONOUNCED DEAD Month 5 Day 10 Year 69	2c. HOUR 12:40 P.M.
3 SEX M		4. RACE W	5. DATE OF BIRTH 22 June 1924	6. AGE (in years) 44 YRS.	IF UNDER YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	9. COUNTY OF DEATH Prince George	
7a. BIRTHPLACE (State or foreign country) Pitts, Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. CITY OR TOWN OF DEATH Camp Springs		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Andrews Air Force Hosp		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.) Sales Mgr.		12b. KIND OF BUSINESS OR INDUSTRY Auto		13a. STREET AND NUMBER 3200 Curtis Drive		
13a. USJA. RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md		13b. COUNTY Prince George		13c. CITY OR TOWN Hillcrest		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14. FATHER'S NAME Frank M. Dunlap
15. MOTHER'S MAIDEN NAME Lucille Ratajeski		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO WW. 11		17. INFORMANT Lorraine B. Dunlap		ADDRESS 2205-Afton St. SE
18 CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 4123 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Unknown								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John Kehoe, M.D., Riverdale		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-10-69
EXAMINER'S NAME (Type)		ADDRESS Wash.,		25a. REC'D BY REGISTRAR MAY 13 1969		25b. REGISTRAR'S SIGNATURE		
23a. BURIAL CREMATION Burial		23b. DATE May 13-69		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Virginia		23d. LOCATION (City or Town) (County) (State)		24. FUNERAL DIRECTOR Simmons Bros. 1661-Gd. Hope Rd. SE. DC



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07323										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07319	
CERTIFICATE OF DEATH																					
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		Month		Day		Year		2b. HOUR					
Paul		E.		Egenreider				May		5		1969		11		30 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		8. UNDER 1 YEAR		9. UNDER 24 HRS									
Male		White		Oct. 9, 1908		60 YRS.		MONTHS		DAYS		HOURS		MIN							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH													
Pennsylvania		U. S. A.		WIDOWED		DIVORCED		Prince George													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY															
Greenbelt		73 G. Ridge Road		Factory Worker		Factory															
3a. USUAL RESIDENCE (Where deceased lived, if institution Residence before death) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER													
Md.		P. G.		Greenbelt		YES		73 G. Ridge Road													
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last							
John		Egenreider		Catherine		Bickner															
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, na, or unknown)		(If yes give year or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address													
no				195 07 1830		Shirley Ann Egenreider		Same as #13													
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, ACUTE																					
DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																					
DUE TO, OR AS A CONSEQUENCE OF (c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
				YES		NO															
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year																			
While at work		P.M.		19																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County		State									
White																					
at work																					
22a. I certify that (I) (this hospital) attended the deceased from 1968, to 3 MAY, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.																					
22b. SIGNATURE										22c. DATE SIGNED											
Arthur Kaufman										4 May 69											
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS											
Arthur Kaufman, M. D.										Greenbelt, Maryland											
23a. BURIAL, CREMATION, REMOVA. (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)											
Burial		5/7/69		East Harrisburg Cemetery		Harrisburg		Dauphin		Pa											
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE	
Francis Gasch's Sons Hyattsville, Maryland										MAY 7 1969										Richard Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07324

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07320

1. DECEASED-NAME (Type or print) ELROD MARY ELMA ELROD			2a. DATE OF DEATH Month MAY Day 16 Year 1969			2b. HOUR 0130 M
3. SEX FEMALE	4. RACE CAU	5. DATE OF BIRTH 16 NOV 1911		6. AGE (In years last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) GEORGIA	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH PRINCE GEORGE'S Md.			
10. CITY OR TOWN OF DEATH ANDREWS A.F. BASE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROSS AFB	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) OFFICE		12b. KIND OF BUSINESS OR INDUSTRY MILITARY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE VA.		13b. COUNTY ARLINGTON	13c. CITY OR TOWN ARLINGTON	13d. INSIDE CITY LIM 1ST YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1310 N. OAK ST.	
14. FATHER'S NAME First DATON Middle - Last ELROD			15. MOTHER'S MAIDEN NAME First BLANCHE Middle - Last IRVIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) YES (If yes give year or dates of service) W.W.II		16b. SOCIAL SECURITY NO. 252-03-4678	17. INFORMANT MARGERY K. GUMBEL Address 453 E. KILGILE ST. N.W. WASHINGTON, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 1621 DUE TO, OR AS A CONSEQUENCE OF MYOCARDIAL METASTASES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Aspiration of food DUE TO, OR AS A CONSEQUENCE OF Adenocarcinoma of Lung (c) Adenocarcinoma of Lung					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 7 May 1969 , to 10 May 1969 , that (I) (we) last saw the deceased alive on 12 May 1969 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Jeffrey Stier MD		DEGREE MD		22c. DATE SIGNED 10 May 69		
22d. PHYSICIAN'S NAME (Type) JEFFREY STIER		22e. ADDRESS MALCOLM GROSS HOSPITAL ANDREWS AIR FORCE BASE, DC				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-14-69		23c. NAME OF CEMETERY OR CREMATORY West View Cemetery		
23d. LOCATION (City or Town) (County) (State) Atlanta Georgia		23e. RECORD BY REGISTRAR W.W. Chambers Co-1400				
24. FUNERAL DIRECTOR W.W. Chambers Co-1400		ADDRESS 1400		25a. REC'D BY REGISTRAR MAY 14 1969		
				25b. REGISTRAR'S SIGNATURE W.W. Chambers		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07325		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07321	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last <i>Elsie B. Ely</i>			2a. DATE OF DEATH Month Day Year <i>May 1 1969</i>		2b. HOUR <i>1:50 P.</i>		
3 SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>10-29-82</i>		6. AGE (In years last birthday) <i>86</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George</i> Md	
10. CITY OR TOWN OF DEATH <i>Cheverley</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Prince George General Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Prince George</i>		13c. CITY OR TOWN <i>Mt. Rainier</i>		13d. NO. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>3109 Bunker Hill Rd</i>		14. FATHER'S NAME First Middle Last <i>William Billingsley</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Eleanor Grambrill</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Husband</i>		Address <i>Same</i>	
18. CAUSE OF DEATH (Enter only one cause per PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF <i>Generalized Arterio-Sclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Generalized Arterio-Sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 min</i> <i>10 yrs.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>4/25</i> , 1969, to <i>5/1</i> , 1969, that (I) (we) last saw the deceased alive on <i>5/1</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Charles C. Hageage M.D.</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>May 1, 1969</i>	
22d. PHYSICIAN'S NAME (Type) <i>Charles Hageage, M.D.</i>				22e. ADDRESS <i>3308 Perry St. Mt. Rainier, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5/3/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Colmar Manor, Md.</i>	
24. FUNERAL DIRECTOR <i>Nalley's Funeral Home Inc.</i>				ADDRESS <i>Mt. Rainier, Maryland</i>		25a. REC'D BY REGISTRAR <i>MAY 6 1969</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Hageage</i>			

1804

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M - 1/69

07326		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07322								
MARTHA CERTIFICATE OF DEATH														
1 DECEASED NAME (Type or print) MARTHA			First MARIE		Middle ETCHISON		Last		2a. DATE OF DEATH Month Day Year 5 24 69			2b. HOUR M		
3. SEX F			4. RACE COLORED			5. DATE OF BIRTH 12-18-88			6. AGE (In years lost birthday) 80 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince Georges Co. Md					
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2664 E.E.F.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.			13b. COUNTY PRINCE GEORGES			13c. CITY OR TOWN New Carrollton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7701 Archant Drive			
14. FATHER'S NAME NOBEL			First S.		Middle COOK		Last		15. MOTHER'S MAIDEN NAME IDA WEEDON			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or Unknown) NO			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 220-540244			17. INFORMANT MRS. IDA V. STEWART			Address 12706 CALDWELL ST ROCKVILLE, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac & Respiratory Arrest 100% DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma of Perit DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Anemia														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Thipavan Thanudape MD			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 6-24-69.					
22d. PHYSICIAN'S NAME (Type)			THIPAVAN THANUDAPE			22e. ADDRESS PRINCE GEORGE'S GENERAL HOSPITAL, MD								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 5-27-1969			23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM			23d. LOCATION (City or Town) (County) (State) COLMAR MANOR, MARYLAND					
24. FUNERAL DIRECTOR W.W. CHAMBERS Co.			RIVERDALE, MD			25a. REC'D BY REGISTRAR DATE MAY 27 1969			25b. REGISTRAR'S SIGNATURE Charles Judge					

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07327

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08796

1 DECEASED NAME (Type or Print)			First John Middle W Last Ewell			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month 5 Day 16 Year 69			2b HOUR M		
3 SEX Male		4 RACE White		5 DATE OF BIRTH 12-16-1916		6 AGE (in years last birthday) 52 YRS		7 UNDER YEAR MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD Month 6 Day 6 Year 69 1:00pm M	
7a BIRTHPLACE (State or foreign country) MARYLAND				7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md			
10 CITY OR TOWN OF DEATH Mt. Rainier				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3121 Queens Chapel Rd. 301				12a USJA1 OCCUPATION (Kind of work done during most of working life, even if retired.) ATTORNEY AT LAW		12b KIND OF BUSINESS OR INDUSTRY	
13a USJA1 RESIDENCE (Where deceased lived if institution Residence before admission) STATE Maryland				13b COUNTY Prince George's		13c CITY OR TOWN Mt. Rainier		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3121 Queens Chapel Rd. 301	
14. FATHER'S NAME First John Middle E. Last EWELL			15 MOTHER'S MAIDEN NAME First WILKINA Middle DANTZ Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16b SOCIAL SECURITY NO (If yes give war or dates of service) KOREAN			17 INFORMANT MR. DOUGLAS W. EWELL			ADDRESS W. NYATTSVILLE, MD 2704 KIRKWOOD PL		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Liver failure</u> 5719 DUE TO, OR AS A CONSEQUENCE OF <u>Cirrhosis of liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home form, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b DATE SIGNED 6-7-69			
23a BURIAL, CREMATION REMOVAL (Specify)				23b DATE JUNE 10, 1969		23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND			
24 FUNERAL DIRECTOR W.W. Chambers Eor Riverdale, Md.				25a REC'D BY REGISTRAR DATE JUN 12, 1969				25b REGISTRAR'S SIGNATURE Thomas Judge			

**FOR STATE
HEALTH DEPT**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 413
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07323

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR			
Raymond		H		Ferguson				5-13-69		19		00		am					
3 SEX	4 RACE	5 DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month		Day		2d. HOUR			
Male	White	12-6-1891		77 YRS		MONTHS		DAYS		5		13		69		11:05am			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH													
WASH. D.C.		USA				Prince George's													
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY							
Cheverly				Prince George Hospital				FARMING				TRUCK FARMER							
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET AND NUMBER			
Maryland				Prince George's				Oxon Hill				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				1514 Ferguson Lane			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME															
First Middle Last				First Middle Last															
ANDREW				FERGUSON				ANNIE A. MOORE											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT ADDRESS											
NO				213-38-2627				MRS. MARY MAYOR - SCOTLAND, MD.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Acute carbon monoxide intoxication																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)																			
19a. DATE OF OPERATION																			
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																			
20. AUTOPSY?																			
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH																			
21b. TIME OF INJURY Month, Day, Year																			
8:00 AM 5-13 19 69																			
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
Connected rubber hose from exhaust pipe to interior of car.																			
21d. INJURY OCCURRED																			
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)																			
21f. LOCATION Street or RFD No. City or Town County State																			
Garage of home Oxon Hill P.G. Md.																			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
22b. DATE SIGNED																			
5-13-69																			
ACTUAL SIGNATURE																			
EXAMINER'S NAME (Type)																			
John Kehoe MD Riverdale, Md.																			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>																			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																			
ADDRESS (Street, city, town, or county)																			
23a. BURIAL, CREMATION, OR REMOVAL (Specify)																			
23b. DATE																			
23c. NAME OF CEMETERY OR CREMATORY																			
23d. LOCATION (City or Town) (County) (State)																			
BURIAL 5/16/69 ST. MICHAELS CEM. RIDGE, MARYLAND																			
24. FUNERAL DIRECTOR																			
25a. REC'D BY REGISTRAR																			
25b. REGISTRAR'S SIGNATURE																			
JOHN M. WELCH - LEONARDTOWN, MD. MAY 19 1969																			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07329

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07324

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) William C. Fones			2a. DATE OF DEATH Month 5 Day 13 Year 69			2b. HOUR- 12:00 AM	
3. SEX Male		4. RACE W		5. DATE OF BIRTH 6/3/1886		6. AGE (In years last birthday) 82 YRS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.	
10. CITY OR TOWN OF DEATH Forestville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Regent Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Govt.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia		13b. CITY OR TOWN Arlington		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 702 South 22nd Street	
14. FATHER'S NAME First Middle Last Henry Fones			15. MOTHER'S MAIDEN NAME First Middle Last Julia Hall				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Henry A. Monroe, Friend Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis 183 X DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of prostate DUE TO, OR AS A CONSEQUENCE OF (c) unknown							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 5/17/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Prostatectomy		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12/11/1966 to May 13, 1969 , that (I) (we) last saw the deceased alive on May 12, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Henry J. Habley				DEGREE MD		22c. DATE SIGNED May 14 69	
22d. PHYSICIAN'S NAME (Type) HENRY J. HABLEY				22e. ADDRESS 4601 Nichols Ave Rco			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/16/69		23c. NAME OF CEMETERY OR CREMATORY Providence Meth. Church Cem.		23d. LOCATION (City or Town) (County) (State) Montross, Virginia	
24. FUNERAL DIRECTOR Robert E. Wilhelm				ADDRESS 4308 Suitland Rd., S., Suitland, Md., 20023		25a. REC'D BY REGISTRAR MAY 19 1969	
				25b. REGISTRAR'S SIGNATURE Glenn J. Jones			



07330

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 7 & 13 Film G413 6/5/69 kk

CERTIFICATE OF DEATH

07325

1 DECEASED NAME (Type or print) <u>Anna</u>		First <u>S.</u> Middle <u>FORSBACKA.</u> Last		2a DATE OF DEATH <u>May</u> Month <u>29</u> Day <u>69</u> Year		2b HOUR <u>5:40</u> PM	
3 SEX <u>FEMALE</u>		4 RACE <u>WHITE</u>		5 DATE OF BIRTH <u>JUNE 6, 1886</u>		6 AGE (In years lost birthday) <u>82</u> YRS.	
7a BIRTHPLACE (State or foreign country) <u>FINLAND</u>		7b CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>PRINCE GEORGES</u> Md.	
10 CITY OR TOWN OF DEATH <u>HYATTSVILLE</u>		11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) <u>HYATTSVILLE HOSPITAL</u> <u>HOME 6500 RIGGS ROAD</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE <u>MARYLAND</u>		13b COUNTY <u>Prince George</u>		13c CITY OR TOWN <u>Takoma Park</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME <u>MATTHEW</u>		First <u>HONGELL</u> Middle Last		15 MOTHER'S MAIDEN NAME First <u>W.</u> Middle Last <u>FORSBACKA.</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> no, or unknown <input type="checkbox"/> If yes give war or dates of service		16b SOCIAL SECURITY NO		17 INFORMANT <u>TAENAR W.</u>		Address <u>FORSBACKA.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							
PART 1 DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Cerebral thrombosis.</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>Arteriosclerotic cardiovascular disease undet.</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
<u>Uremia</u>							
19a DATE OF OPERATION		19b CONDIT.ON FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Apr 15, 1969</u> to <u>May 29, 1969</u> , that (I) (we) last saw the deceased alive on <u>May 28, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>William F. Simpson</u>		DEGREE <u>M.D.</u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <u>5/29/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>William F. Simpson M.D.</u>		22e ADDRESS <u>6216 N.H. Ave NE - DC 20011</u>					
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE <u>JUNE 2-1969</u>		23c NAME OF CEMETERY OR CREMATORY <u>Georgetown Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>P. Geo. Md.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		ADDRESS <u>254 Carroll St. N.W.</u>		25a. RECEIVED BY REGISTRAR <u>JUN 29 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William F. Simpson</u>	

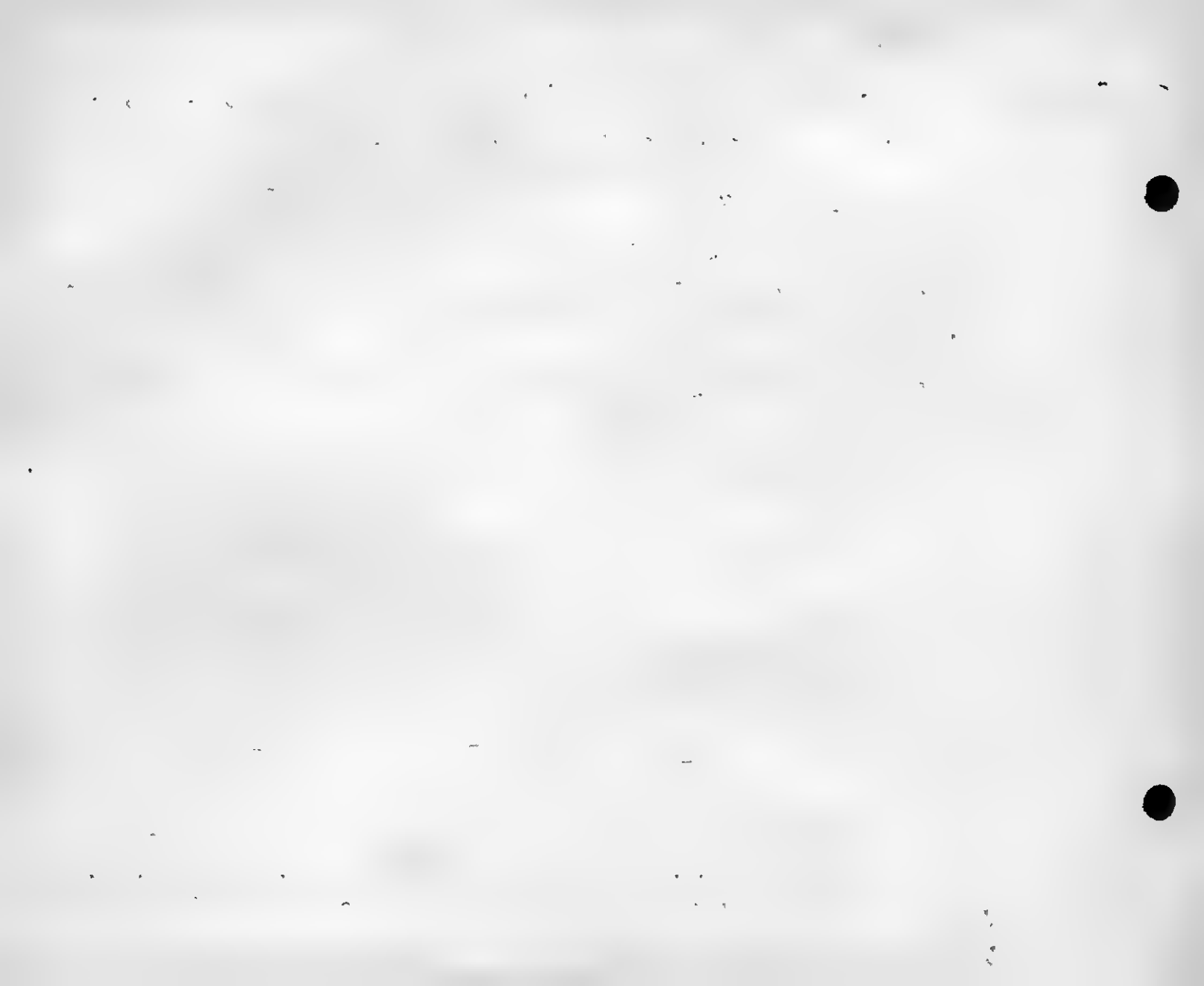
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) First Middle Last GEORGE BENJAMIN FOWLER					2a DATE OF DEATH Month Day Year MAY 3 1969		2b HOUR 9:15P.M.		
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH 7 JULY 1892		6 AGE (in years last birthday) 76 YRS		7 UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH PRINCE GEORGE'S Md			
10 CITY OR TOWN OF DEATH RIVERDALE		11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) 6501 AUBURN AVE			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TAXI DRIVER		12b KIND OF BUSINESS OR INDUSTRY		
13a SOCIAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b COUNTY PRINCE GEORGES		13c CITY OR TOWN RIVERDALE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 6501 AUBURN AVE.	
14 FATHER'S NAME First Middle Last SAMUEL FOWLER			15 MOTHER'S MAIDEN NAME First Middle Last LAURA BRADY						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NONE			16b SOCIAL SECURITY NO 579054562		17 INFORMANT Address TERETHA B. FOWLER SAME AS # 13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO, OR AS A CONSEQUENCE OF Carcinoma of lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH over 8 mo.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 5-3-69			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			22a LOCATION Street or R.F.D. No City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from 9-9-68 , 19__, to 5-3-69 , 19__, that (I) (we) lost saw the deceased alive on 5-3-69 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE John Kehoe					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 5-5-69		
22d. PHYSICIAN'S NAME (Type) John Kehoe M.D.					22e ADDRESS 6300 Riverdale Rd., Riverdale, Md.				
23a BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b DATE 6 MAY 1969		23c NAME OF CEMETERY OR CREMATORY WASHINGTON NATL. CEM		23d LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND			
24 FUNERAL DIRECTOR W.W. CHAMBERS CO RIVERDALE, MD					25a REC'D BY REGISTRAR MAY 8 1969		25b REGISTRAR'S SIGNATURE Chambers Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-100. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07332

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07327

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			Month Day Year			2b HOUR		
William James French						DATE MATED			5-29-69			19 12:25am		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR			
Male	White	4-3-1903	66 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year			5 29 69 1:15am M			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			Md.		
Pa.			U.S.A.						Prince George's					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY					
Cheverly			Prince George Hospital			Ret. Bar Tender			Bar					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before)			13b CITY OR TOWN			13c INSIDE CITY LIMITS?			13d STREET AND NUMBER					
STATE: Pennsylvania			Allegheeny			YES <input type="checkbox"/> NO <input type="checkbox"/>			606 Cedar Avenue					
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
William French			Mary ?											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT			3745 Donnett Drive					
no			210 07 9293			Eleanor Sheeler			Forestville, Md.					
B CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure												minutes		
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease												over 1 yr.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
DUE TO, OR AS A CONSEQUENCE OF														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?						
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
				P.M. 19										
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED						
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				5-29-69						
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										
				ADDRESS (Street, city, town, or county)										
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORIUM						
Burial				6/3/69				Northside Catholic						
								Pittsburg Pa						
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REG STRAR						
Francis Gasch's Sons				Hyattsville, Md.				JUN 2 1969						
								25b REGISTRAR'S SIGNATURE						
								Charles Judge						



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TOTAL FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4/23

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07333

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07328

1 DECEASED-NAME (Type or print) First Middle Last Madeline B. Frey			2a DATE OF DEATH Month Day Year 5 13 69			2b HOUR 120 A M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH 5/5/ 1915 lost birthday) 5-5 xxxxx		6 AGE (In years lost birthday) 54 xxx YRS	
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARR ED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George Md	
10 CITY OR TOWN OF DEATH Riverdale		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Secretary		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c CITY OR TOWN Hyattsville		13d INS DE CITY, LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 16066 39th Ave.		14. FATHER'S NAME First Middle Last James Boole		15. MOTHER'S MAIDEN NAME First Middle Last Della C. Bailey			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, or (unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO 056-14-8912		17 INFORMANT Hosp. Record		Address Phone Mr. Grady C. Frey (Husband) 777-5095	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4123				DUE TO, OR AS A CONSEQUENCE OF PULMONARY EDEMA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.				(b) ARTERIOSCLEROTIC CORONARY		UNKNOWN	
				(c) ARTERY DISEASE			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5-7 , 19 67 , to 5-13 , 19 69 , that (I) (we) last saw the deceased alive on 5-13 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C. J. Houmann				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 13 MAY 1969	
22d. PHYSICIAN'S NAME (Type) C. J. HOUMANN				22e. ADDRESS RIVERDALE MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/16/69		23c. NAME OF CEMETERY OR CREMATORY Pinecrest Cemetery		23d. LOCATION (City or Town) (County) (State) Sebring, Highlands Fla.	
24 FUNERAL DIRECTOR F. Gasch's Son Funeral Home				25a. REC'D BY REG STRAR Hyattsville Maryland		25b. REGISTRAR'S SIGNATURE May 19 1969	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07334

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07329

1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN <input type="checkbox"/> Month Day Year				2b HOUR			
George		N				Fuqua		2a DATE KNOWN <input checked="" type="checkbox"/> 5-23-69 192:40pm							
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR		8 UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR			
Male	White	Feb. 11, 1914		55 YRS		MONTHS		DAYS		5 Month 23 Day 69 Year 19 2:56pm					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH									
Ky.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's		Md							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY							
Cheverly		Prince George Hospital				Salesman		Shoe Store							
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER							
Maryland		Prince George's		Harlowe Heights		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6110 Dallas Place, #102							
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last	
George		Marvin		Fuqua		Hanora		Burk							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b SOCIAL SECURITY NO		17. INFORMANT		4009 Gallatin Street Hyattsville, Maryland									
Yes		WW 11		416 05 7506		Josephine Rich									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of head												minutes			
955X															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c) DUE TO, OR AS A CONSEQUENCE OF															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
				12:40pm 5-23-19 69				Shot self at home							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State							
				Home				same as #13							
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				John Kehoe MD				22b. DATE SIGNED				5-24-69			
EXAMINER'S NAME (Type)				John Kehoe MD Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
								ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)									
Burial		5/28/69		Baltimore National		Baltimore Baltimore Md.									
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Francis Gasch's Sons				Hyattsville, Md.				JUN 2 1969		John Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07335

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07330

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)			First MORTON Middle WILMORE Last GALLOWAY			2a DATE OF DEATH Month Day Year May 7 1969			2b HOUR 7:20 PM		
3 SEX Male			4 RACE White			5. DATE OF BIRTH Nov. 16, 1896			6 AGE (In years last birthday) 72 YRS.		
7a BIRTHPLACE (State or foreign country) Washington D.C.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARR.ED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George Md		
10 CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk			12b KIND OF BUSINESS OR INDUSTRY Store		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b COUNTY P. G.			13c CITY OR TOWN Bladensburg			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER 3503 49th Ave.			14. FATHER'S NAME First Middle Last Sheridan Galloway			15 MOTHER'S MAIDEN NAME First Middle Last Mary W. Taylor					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b SOCIAL SECURITY NO. 577 07 3509			17. INFORMANT Address Ella Z Galloway Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Heart myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>2 months</u> <u>years</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerotic disease of the heart - Myocardial Infarction - Congestive Heart Failure</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 19 69</u> , to <u>5-7</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-7</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Donald C. Edgren</u>			DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <u>5-8-69</u>					
22d. PHYSICIAN'S NAME (Type) DONALD C. EDGREN			22e. ADDRESS <u>6201 Springfield Rd. College Park, Md.</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/10/69			23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln			23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.		
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland			25a. REC'D BY REGISTRAR MAY 12 1969			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

1538

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07336 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07331
Item 6 Film 413 6/6/69 kk CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last <i>Lena A. Gamble</i>			2a. DATE OF DEATH Month Day Year <i>5 30 69</i>			2b. HOUR <i>8:53 PM</i>		
3. SEX <i>Female</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>3/15/05</i>		6. AGE (In years lost birthday) <i>64</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>S.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George's Co.</i> Md		
10. CITY OR TOWN OF DEATH <i>Cheverly</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>GGGH - ECF</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		
13a. US. AL RESIDENCE (Where deceased lived, if institution) STATE <i>Maryland</i>			13b. COUNTY <i>Prince Georges</i>		13c. CITY OR TOWN <i>Cedar Heights</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <i>Butler Bennett</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Doshier ?</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>579-05-771</i>		17. INFORMANT <i>Harry Gamble - 6412 Lee Place Cedar Heights, Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Metastatic carcinoma - Primary Colon.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Extensive Metastasis.</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Paraplegia</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (this hospital) attended the deceased from <i>7 May</i> , 19 <i>69</i> , to <i>30 May</i> , 19 <i>69</i> , that (we) last saw the deceased alive on <i>30 May</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. D. RECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>30 May 69</i>		
22d. PHYSICIAN'S NAME (Type) <i>P.C. XAVIER, M.D.</i>				22e. ADDRESS <i>Prince Georges General Hospital - Cheverly, Md.</i>				
23a. BURIAL, CREMATION REMOVAL (Specify) <i>6-5-69</i>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <i>HARMONY</i>		23d. LOCATION (City or Town) (County) (State) <i>Highland Park Md</i>		
24. FUNERAL DIRECTOR <i>H.S. Washington & Sons 4925 Deane Ave. NE</i>				25a. REC'D BY REGISTRAR DATE JUN 3 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07337

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07332

1. DECEASED NAME (Type or print)		First Frances	Middle R.	Last Garman	2a. DATE OF DEATH Month Day Year May 26 1969		2b. HOUR 40 P.M.	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH Oct. 8, 1889			6. AGE (in years lost birthday) 79 YRS.	7. FUNERAL YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges		12b. KIND OF BUSINESS OR INDUSTRY Md		
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6500 Riggs Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Home Nursing		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (If deceased lived in institution- Residence before admission) Washington D.C.	13b. COUNTY N	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3019 Channing St., N.E.				
14. FATHER'S NAME First Middle Last Martin Rook		15. MOTHER'S M AIDEN NAME First Middle Last Nettie Gearheart						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. none		17. INFORMANT Jay H. Garman Same as #13				Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic Cardiovascular Disease</u> 10 yr. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u> 10 yr.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased, from <u>March</u> , 1969, to <u>26 May</u> , 1969, that (I) (we) last saw the deceased alive on <u>26 May</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Wm. D. Wimala</u>		DEGREE <u>MD</u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>26 May 69</u>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
23a. BURIAL CREMATION, REMOVAL (Specify) Cremation		23b. DATE 5/27/69		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.		
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR JUN 2 1969		25b. REGISTRAR'S SIGNATURE <u>Francis Judge</u>		

FOR STATE
HEALTH DEPT.

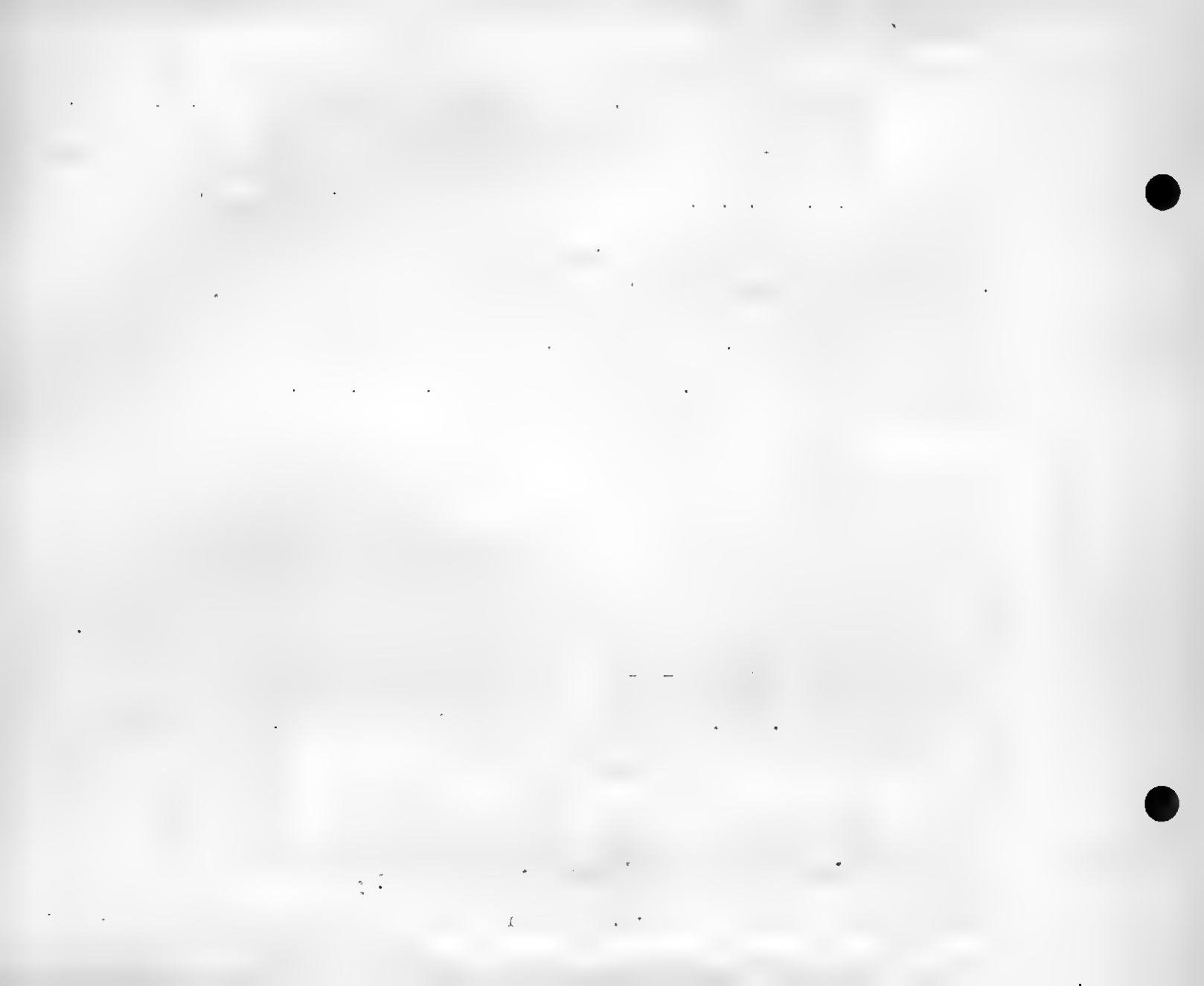
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07338 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07333

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year				2b. HOUR	
Anthony		James		Garufi		5-17-69 199:05pm M				2d HOUR			
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD				2d HOUR	
Male	White	1-8-1947	22 YRS.	MONTHS		DAYS		5 Month 17 Day 69 Year 9:05pm M					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH						Md	
Washington D.C.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's							
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY							
Cheverly		Prince George Hospital		Carpenter		Building							
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before death)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER							
Maryland		Prince George's Rogers Heights		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4907 55th. Place							
14. FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle	
Henry		R.		Garufi Sr.		Helen		Carrigan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS							
no		217 44 4567		Henry R. Garufi Sr.		Same as # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Stab wound of chest													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
				8:30pm 5-17- 1969				Stabbed during altercation					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State					
				73rd. Ave. and Landover Road, Prince George County, Maryland									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				5-19-69					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS(Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial				5/21/69		Et. Lincoln		Colmar Manor P.G. Md.					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Francis Gasch's Sons				Hyattsville, Md.				MAY 23 1969		Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

073339

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07334

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF EST. DEATH			Month Day Year			2b HOUR			
Willis Anthony Gault						5-18-69			19 11			42pm			
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c DATE PRONOUNCED DEAD			2d HOUR				
male	white	1-21-1938	31 YRS					5 19 69			12:16am				
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.			
Washington, D.C.			USA						Prince George's						
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY						
Cheverly			Prince George Hospital			Insurance Agent			Metropolitan						
13a USUA. RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET AND NUMBER			
Maryland			Prince George's			Camp Springs			YES <input type="checkbox"/> NO <input type="checkbox"/>			7255 McKinley Street			
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
Willis M. Gault			Katherine L. Amel												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS						
no						Patricia L. Gault, Wife			7255 McKinley St., Camp Springs, Md. 20031						
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of chest															
965x DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?							
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M.				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
				11:40pm 5-18- 19 69				shot during altercation							
22 INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
				Outside Quonset Hut.				3225 Naylor Rd., Prince George County, Md.							
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED							
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				5-20-69							
John Kehoe MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)							
Riverdale, Md.															
23a BURIAL, CREMATION REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)			
Burial				5/22/69				Macedonia Methodist Church				Winchester, Virginia			
24 FUNERAL DIRECTOR				25a RECD BY REGISTRAR				25b REGISTRAR'S SIGNATURE							
Robert E. Wilhelm Funeral Home				4307 Suitland Road, S.E., Suitland, Md. 20023				MAY 23 1969				Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07340

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07335

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month 16, Day 1969 Year		2b. HOUR 12:50 AM	
Willie		John		Gibson				
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 10-17-34		6. AGE (In years last birthday) 34 YRS.		7. UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gne. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD		13b. COUNTY Prince George's		13c. CITY OR TOWN Landover		13d. RESIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 121 82nd Avenue
14. FATHER'S NAME First Middle Last Fred Gibson		15. MOTHER'S MAIDEN NAME First Middle Last Elivina Gibson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT Address Eloise Gibson 121 - 82nd Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory arrest due to delirium tremens 2110 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that XX (this hospital) attended the deceased from May 14, 1969 to May 16, 1969, that XX (we) lost saw the deceased alive on May 16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Guillermo Olivos M.D.				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED MAY 16, 1969		
22d. PHYSICIAN'S NAME (Type) Guillermo Olivos, M.D.				22e. ADDRESS Prince George's Gen. Hospital, Cheverly				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/19/69		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park		23d. LOCATION (City or Town) (County) (State) 7601- Sheriff Rd. Md.		
24. FUNERAL DIRECTOR Washington Funeral Chapel				475- H St. N.W.		25a. REC'D BY REGISTRAR MAY 23 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07341

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07336

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year			2b. HOUR	
GRACE D. GOLDENBERG					MAY 13, 1969			7P M	
3 SEX	4 RACE	5 DATE OF BIRTH			6 AGE (in years last birthday)	F UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE	CAUCASIAN	JULY 19, 1880			88 YRS.	MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
KENTUCKY	U.S.			PRINCE GEORGE'S Md					
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
GREENBELT	GREENBELT CONVALESCENT CENTER		HOUSEWIFE						
13a USUAL RESIDENCE (Where deceased admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER					
MARYLAND	PRINCE GEORGE'S	SEABROOK		9604 VAN BUREN					
14 FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last	
DANIEL			DELANEY	FLORENCE				MANBY	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT			Address		
No		UNKNOWN		MRS VIRGINIA. KAECHLE			SANDAS #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>									
4409 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) (b) <u>Generalized arteriosclerosis</u>									
storing the underlying cause (c) <u>Generalized arteriosclerosis</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour AM Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm, street factory, office building, etc)		21f LOCATION		Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>March 13, 1969</u> , to <u>May 13, 1969</u> , that (I) (we) last saw the deceased alive on <u>May 11, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE				22c DATE SIGNED					
<u>Dow B. Cameron</u>				<u>May 14, 1969</u>					
22d PHYSICIAN'S NAME (Type)				22e ADDRESS					
<u>Dow B. Cameron</u>				<u>MT. RAINIER, MARYLAND.</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)
<u>BURIAL</u>		<u>17 MAY 1969</u>		<u>SPRING GROVE CEM</u>		<u>CINCINNATI, OHIO</u>			
24 FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
<u>W.W. CHAMBERS CO. RIVERDALE, MD.</u>				<u>MAY 19 1969</u>		<u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-5 (11-60)
30A REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) EDITH EVELYN GORRICK			2a. DATE OF DEATH Month MAY Day 13 Year 1969			2b. HOUR M			
3 SEX F		4 RACE W		5. DATE OF BIRTH JULY 8, 1900		6 AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS 68 DAYS 68 HOURS 68 MIN	
7a. BIRTHPLACE (State or foreign country) Balt Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE Md.			
10. CITY OR TOWN OF DEATH RIVERDALE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) LELAND MEM. HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD		13b. COUNTY P.G.		13c. CITY OR TOWN LAUREL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 15401 ALAN DRIVE	
14 FATHER'S NAME First O'Donnell Middle O'Donnell Last O'Donnell			15 MOTHER'S MAIDEN NAME First Leleig Middle Troupe Last Troupe						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. 4109		17. INFORMANT Louis J. Garrick, Laurel Md		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) congestive heart failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11-27, 1968 to 5-12, 1969 , that (I) (we) lost saw the deceased alive on 5-12, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Fernando Mayones MD		22c. DATE SIGNED 5-16-69		22d. PHYSICIAN'S NAME (Type) G. A. de la TORRE MD		22e. ADDRESS 324 Monticuey St. Laurel Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE May 16, 1969		23c. NAME OF CEMETERY OR CREMATORY London Park		23d. LOCATION (City or Town) (County) (State) Baltimore Md.			
24. FUNERAL DIRECTOR Donald Dean Funeral Home Laurel Md		25a. REC'D BY REGISTRAR MAY 22 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
Minnie		D.	Goss		Month	Day	Year	11 15 M	
3. SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	Caucasian		01/25/88		81 YRS.		MONTHS	DAYS	HOURS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Vermont		U. S. A.				Prince Georges Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Adelphi		1801-Metzerott Manor Care, Adelphi		Homemaker					
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY (LAW 157) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Va.		Arlington		N.A.		5302-Little Falls Rd.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Joseph		A. DeBoer		Augusta		A. Featherley		Address 1801-Metzerott Rd.-Adelphi, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4109		Heart Failure				15 minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Myocardial Infarction		DUE TO, OR AS A CONSEQUENCE OF		(c) Arteriosclerotic Cardiovascular Disease			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		Bronchial Asthma							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21c. LOCATION		Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 5-20-1967, to 5-28-1967, that (I) (we) last saw the deceased alive on 5-20-1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
Morton Altshuler, M.D.								5-28-67	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVA (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Morton Altshuler, M.D.		9205-New Hampshire Ave. Silver Spring, Md.		Cremation		May 23, 1969		Cedar Hill Crematory	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		23d. LOCATION (City or Town) (County) (State)			
Ives Funeral Home		25a. 2347 Wilson Blvd. Arlington, Virginia		J. Charles Judge		Suitland, Maryland			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

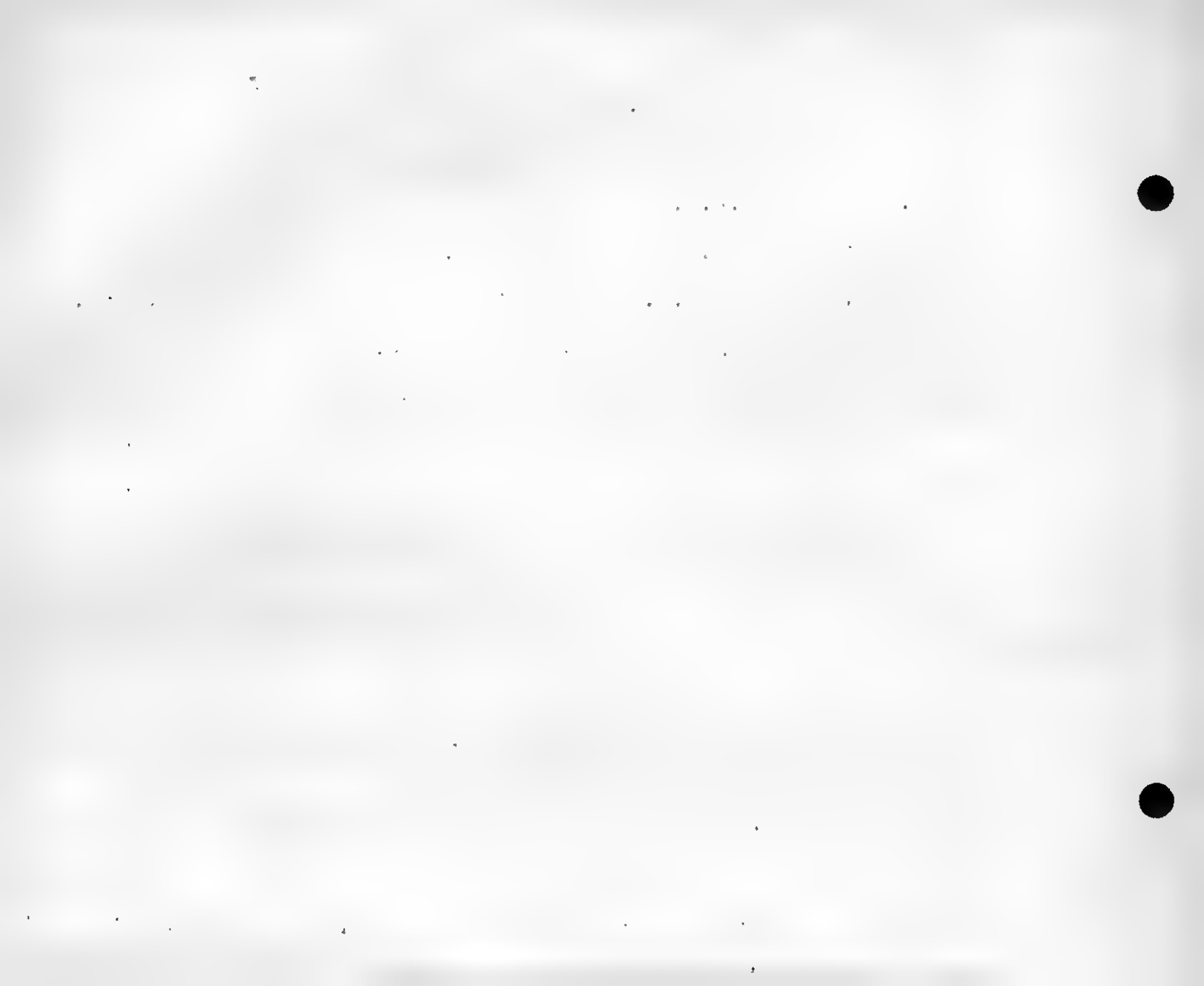
MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR P M
Paul			D. Griga			5 25 69			6:28 P
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
male		white		12/18/1902		66 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Germany		USA				Prince Georges Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince Georges Hospital			Salesman		Retail	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY PG		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MD			PG		Camp Springs				7819 Coolridge Drive
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Daniel Griga				Augusta Recklies					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
no			578-38-7265		Miss Linca Griga, Daughter 7819 Coolridge Drive, Camp Springs, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH CAUSED BY: IMMEDIATE CAUSE (a) Sudden death, presumed myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive cardiovascular disease. DUE TO, OR AS A CONSEQUENCE OF (c) 4130 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15+ years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June, 1965, to May, 1969, that (I) (we) last saw the deceased alive on May 19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Richard M. Huffman, M.D.					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5/26/69		
22d. PHYSICIAN'S NAME (Type) Richard M. Huffman, M.D.					22e. ADDRESS 2001 Eye St. N.W.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Cremation		5/28/69		Cedar Hill		Suitland, Maryland			
24. FUNERAL DIRECTOR Robert E. Wilhelm, Funeral Home 4308 Suitland Road, S.E., Suitland, Md., 20022					25a. REC'D BY REGISTRAR JUN 1 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15/4/69
45M

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
07345										
CERTIFICATE OF DEATH										
07340										
1. DECEASED NAME (Type or print) First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR F				
Earl Thomas Grubbs			May 20, 1969			4:55M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (n years last birthday)		7. UNDER 1 YEAR MONTHS DAYS		
Male		Caucasian		Feb. 6, 1917		52 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Va.		U.S.A.				Prince Georges Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale			E. Leland Mem. Hosp.							
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			P.G.		Hyattsville				7719 Garrison Rd.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Leon T. Grubbs			Loula Ann Slagle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
Yes			WW 11		218 54 7272 Evelyn M. Grubbs Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE								18 DAYS		
DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION								18 DAYS		
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
ACUTE PNEUMONITIS										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from 5 3, 19 69, to 5 20, 19 69, that (I) (we) last saw the deceased alive on 5 20 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE C. J. Houmann				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-20-69				
22d. PHYSICIAN'S NAME (Type) C. J. HOUMANN M.D.				22e. ADDRESS RIVERDALE MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		5/23/69		Ft. Lincoln		Colmar Manor P.G. Md.				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
Francis Gasch's Sons Hyattsville, Md.				MAY 23 1969						



1579

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH																													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																													
07346 CERTIFICATE OF DEATH 07341																													
1. DECEASED-NAME (Type or print)			First Susan			Middle Ellen			Last Gunn			2a. DATE OF DEATH Month May			Day 20			Year 1969			2b. HOUR 4:45 AM								
3 SEX Female			4 RACE White			5. DATE OF BIRTH 02-22-95			6 AGE (In years last birthday) 74 YRS.			F UNDER YEAR MONTHS			OAYS			IF UNDER 24 HRS HOURS			MIN								
7a. BIRTHPLACE (State or foreign country) Ireland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Prince George's Md																				
10. CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of work ng) (e, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home																				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD			13b. COUNTY Prince George's			13c. CITY OR TOWN Glen Dale			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER Daisy Lane																	
14 FATHER'S NAME First Owen			Middle Mulligan			Last Emily			15 MOTHER'S MAIDEN NAME First Emily			Middle Martin			Last Martin														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes WW I			16b. SOCIAL SECURITY NO 213 01 1314			17 INFORMANT Josephine C. Probst			Address Same as #13																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u>																		15 minutes											
1579 DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic malignancy</u>																		months											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Carcinoma of the pancreas</u>																		months											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus</u>																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town			County			State														
22a. I certify that (I) (this hospital) attended the deceased from <u>5/19</u> , 19 <u>69</u> , to <u>5/20</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/19</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>David M. Goldman MD</u> DEGREE																		ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>5/20/69</u>		
22d. PHYSICIAN'S NAME (Type) David M. Goldman, M.D.																		22e. ADDRESS Suite 100 Center Building Hyattsville											
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/22/69			23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City or Town) Arlington			(County) Arlington			(State) Va.														
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.																		25a. REC'D BY REGISTRAR DATE MAY 23 1969			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR-100 (4)
30M. REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
07347										
Items 14, 15, taken from birth certificate										
CERTIFICATE OF DEATH										
07342										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Baby Boy Hamilton						Month Day Year May 15 1969		12:35P		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
Male		White		05-15-69		YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
USA						Prince George's Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's Gen. Hosp.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Res. dence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MD			Prince George's		Hyattsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		2007 Ogleshome	
14. FATHER'S NAME			15. MOTHER'S M.A.D.E.N NAME							
First Middle Last			First Middle Last							
Richard Anthony Hamilton, Jr.			Charlotte Lee McShorter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Imaturity										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) Atelectasis Neonatorum										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No.						
22a. I certify that (X) (this hospital) attended the deceased from May 15, 1969 to May 15, 1969, that (X) (we) last saw the deceased alive on May 15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Hugh Clark, M.D.									May 15-1969	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
					7309 Riggs Road - Hyattsville					
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Cremation		5-24-69		Prince George's Gen. Hosp.		Cheverly, Prince Georges, Md.				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Harry W. Penn, Jr., Administrator					MAY 28 1969		Charles Judge			

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of Vital Records, 301 W. Preston Street, Baltimore, Maryland 21201

07343

MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR
Joan Elizabeth Hayes								MAY 23 1969		8:00 PM
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD		2d HOUR	
M	W	1 Sept 1930		38 YRS			Month 5 Day 23 Year 19 69		10:00 AM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				MD
Maryland		U.S.A.				Prince George				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince George								
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Md.		Prince George		Berwyn		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8525 60th pl.		
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME								
Joseph Glenroy		MARION PRATT								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
No				James Hayes		# 132				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute barbiturate intoxication										
DUE TO, OR AS A CONSEQUENCE OF										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c) DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		7:45 PM 5-23 19 69		Ingested overdose of barbiturate						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory office building, etc)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
		Home		Berwyn		P.G.		Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b. DATE SIGNED						
John Kehoe, M.D., Riverdale				5-24-69						
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		MAY 27, 1969		Mt. OLIVET		WASH. DC				
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Wm. Tattam				DATE MAY 27 1969		R. Charles Jones				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07349									
07344									
1. DECEASED NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR		
First Middle Last					Month Day Year		Hour		
Clarence Robert Hazelrigg					May 15, 1969		3:4 M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		Sept. 5, 1899		69 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Illinois		U. S. A.				Prince George Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George Hospital		Ret. Book Binder		G. P. O.			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.		P. G.		District Heights		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2118 County Rd. Apt. #1	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Henry F. Hazelrigg			Martha A. Christensen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT				
Yes			WW 1		Address				
			329 01 2500		Lura A. Hazelrigg Same as #13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cardiac arrhythmias</u>									
4123 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>ASHD</u>									
15-20m									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Emphysema</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No					
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1968</u> , to <u>5/15, 1969</u> , that (I) (we) last saw the deceased alive on <u>5/8, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
<u>Charles F. Colao</u>								5/15/69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Charles F. Colao				1630 Minnesota Ave SE					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/19/69		Graceland Cemetery		Decatur Machon Illinois			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis Gasch's Sons Hyattsville, Md.						MAY 19 1969		<u>Charles Judas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

19 07350

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07345

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Icie			T.		Heartley	May 7 1969			4:04P ^M		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		01-30-05		64 YRS.					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia		U. S. A.				Prince George's Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's Gen. Hop.			Housewife			Own Home		
13a U.S.A. RESIDENCE (Where deceased admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MD			Prince George's			Beltsville		YES		4910 Talbot Ave.	
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Philmore					Croson	Annie					Saffer
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT Address					
no			579 05 9834			William Henry Heartley Sr. Same as # 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Ischemia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>one day</u> <u>5 years</u> <u>5 years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f LOCATION Street or R.F.D. No			City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 1965, to <u>May</u> , 1969, that (I) (we) last saw the deceased alive on <u>4-25</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (aid not) view the body after death.											
22b SIGNATURE <u>[Signature]</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED			
22d PHYSICIAN'S NAME (Type) <u>O. SAHAKIAN</u>						22e ADDRESS <u>8001 Landover Rd. Clarks Md</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town)		(County)	(State)
Burial			5/10/69		Ft. Lincoln			Colmar Manor		P. G.	Md.
24. FUNERAL DIRECTOR ADDRESS						25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE			
Francis Gasch's Sons Hyattsville, Md.						MAY 12 1969		<u>[Signature]</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF EST. DEATH MATED		2b HOUR	
Richard Hendricks						5-18-69 10:50pm			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		2d HOUR	
Male	White	5-8-1916	53 YRS	MONTHS	DAYS	5 18 69		11:03pm	
7a BIRTHPLACE (State or foreign country)		7b CT ZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md	
Indiana		USA				Prince George's			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Riverdale			Leland Memorial Hospital						
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital give street address)			13b CITY OR TOWN		13c INSIDE CITY - HTS?		13e STREET AND NUMBER		
Maryland			Prince George's Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6700 Bellcrest Road		
4. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			ADDRESS			
First Middle Last			First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes - over 5 yrs.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
2a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED	
John Kehoe MD			Riverdale, Maryland					5-19-69	
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Removal			5/21/1969		Anatomical Board of Md.		Baltimore Md.		
24 FUNERAL DIRECTOR					25a REC'D BY REG STRAR		25b REGISTRAR'S SIGNATURE		
Chambers Funeral Home Hyattsville, Maryland					MAY 26 1969		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
Minnie				A	Hillmuth	May	27	1969	7:40P M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		02-10-82		87 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
N. CAROLINA		U.S.				Prince George's Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George's Gen. Hosp		HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD		Prince George's		Hyattsville				7611 23rd Avenue	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)					
First Middle Last		First Middle Last		16b. SOCIAL SECURITY NO.					
ROBERT ALEXANDER		MARY LOUISE TAYLOR		NONE					
16c. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16d. SOCIAL SECURITY NO.		17. INFORMANT					
NO		NONE		MRS LOUISE WIMPÉE 6831B RIVERDALE RD RIVERDALE, MD 20840					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe coronary arteriosclerosis with occlusion</u> (b) <u>Sonility</u> (c) <u>Autocausis</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED <input type="checkbox"/> WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>2-2</u> , 1967, to <u>5-27</u> , 1969, that (I) (we) last saw the deceased alive on <u>5-27-69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
		5-28-69		Leon Levitsky, M.D.					
22e. ADDRESS		22f. ADDRESS							
		3408 Rhode Island Ave. Mt Rainier							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		5-31-1969		WASHINGTON NATIONAL		SUITLAND MARYLAND			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
C.W. CHAMBERS		60 RIVERDALE, MD		DATE JUN 2 1969		Charles Judge			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 6/19/69 **07353** MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07348

1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH				2b HOUR	
Carl Dewey Hopkins Jr								Month Day Year 5 30 19 69				6:20 a.m.	
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (In years last birthday)	F UNDER 1 YEAR		F UNDER 24 HRS		2c DATE PRONOUNCED DEAD				2d HOUR
M	White	22 Jan 1932		37 YRS	MONTHS DAYS		HOURS MIN		Month Day Year 5 Day 30 Year 19 69				6:50 a.m.
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Penn.		U. S. A.				Prince George Md							
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR PROFESSION	
Riverdale				Leland Hospital				Personal				Government	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b COUNTY				13c CITY OR TOWN				13d. INSIDE CITY LIMITS?	
Md.				Prince George St. Pleasant				YES <input type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				13e STREET AND NUMBER					
First Middle Last				First Middle Last				313 Wilburn Drive.					
Carl D. Hopkins Sr.				Viven Webb									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS	
Yes				Koren				184 24 0496				Jeanne C. Hopkins Same as #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
41a Heart failure												Min	
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b) Arteriosclerotic heart disease												8 yrs.	
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				5-30-69					
John Kehoe, M.D., Riverdale				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c. NAME OF CEMETERY OR CREMATORY					
Burial				6/2/69				Resurrection Cemetery Clinton P. G. Md.					
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR					
Francis Gasch's Sons Hyattsville, Md.								JUN 4 1969					
								25b. REGISTRAR'S SIGNATURE					
								[Signature]					

7341

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07354

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07349

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month		Day	Year	2b. HOUR P. M.	
Mary			L.	Jackson	May		30	1969	2:00 P.	
3. SEX Female		4 RACE Negro		5 DATE OF BIRTH 3/10/1922		6 AGE (in years last birthday) 47		7 UNDER 1 YEAR MONTHS		8 UNDER 24 HRS HOURS
7a BIRTHPLACE (State or foreign country) Washington D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md				
10 CITY OR TOWN OF DEATH Glenn Dale		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital		12a USCA OCCUPATION (Kind of work done during most of working life, even if retired) Domestic		12b KIND OF BUSINESS OR INDUSTRY --				
13a USAL RESIDENCE (Where deceased lived, admission) STATE D.C.		13b COUNTY 136 COUNTY		13c CITY OR TOWN Washington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1322 Stevens Road S.E.		
14 FATHER'S NAME First		Middle	Last	15 MOTHER'S MAIDEN NAME First		Middle	Last			
Samuel			Jackson	Annie			Tolson			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> or unknown) (If yes give war or dates of service) None		16b SOCIAL SECURITY NO 577-24-9474		17 INFORMANT Decedent		Address				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Disseminated lupus erythematosus with extensive</u> DUE TO, OR AS A CONSEQUENCE OF <u>vasculitis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 5 mos										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes mellitus secondary to corticosteroid administration.</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <u>12/28/</u> , 19 <u>66</u> , to <u>5/30/</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>5/30/</u> , 19 <u>69</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) not view the body after death.										
22b. SIGNATURE <u>William J. Washington, Jr. MD</u>		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>May 30, 1969</u>				
22d. PHYSICIAN'S NAME (Type)		<u>William J. Washington, Jr., M.D.</u>			22e. ADDRESS <u>Glenn Dale Hospital Glenn Dale, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>6-6-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>		23d. LOCATION (City or Town) <u>Suitland</u>		(County) (State) <u>Md</u>		
24 FUNERAL DIRECTOR <u>W. S. Womack</u>		ADDRESS <u>4925 Doner One NE</u>			25a. REGISTRY JUN 3 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
07355					07350						
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR			
Bernard Jenkins					5 Month 20 Day 69 Year			10:45a			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years birthday)		IF UNDER 1 YEAR MONTHS DAYS			
Male		white		3/17/1900		69 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia		USA				Prince George					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale			Eugene Leland Memorial			Maintenance			Hyattsville		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY, APTS?		13e. STREET AND NUMBER	
Maryland			Prince George			Hyattsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		4217 Jefferson St.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
Eastham Jenkins			Mary Leake								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT Address					
no			578 03 5776			Spouse and Medical Records					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION										18 DAYS	
DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CORONARY ARTERY DISEASE										UNKNOWN	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION							
				Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 5-20-1969, to 5-20-1969, that (I) (we) lost the deceased alive on 5-20-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				22c. DATE SIGNED							
C. J. HOUHANN				20 MAY 69							
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
C. J. HOUHANN MD				RIVERDALE MD							
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town)		23e. (County)		23f. (State)	
Burial		5/23/69		Wood Bine Cemetery		Harrisonburg				Va.	
24. FUNERAL DIRECTOR				25a. REC'D BY REG. STR.				25b. REG. STR.'S SIGNATURE			
Francis Gasch's Sons				MAY 23 1969				Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

41379

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07356									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Eagle			P.		Johnson	3 30 69			8 35 PM
3 SEX	4. RACE		5. DATE OF BIRTH			6 AGE (In years lost birthday)		7. IF UNDER 1 YEAR	
M	W		12/20/94			74 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		U.S.A.				Prince Georges Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Adelphi			MANOR CARE 1801 MONTGOMERY AVE ADELPHI						
13a. USUAL RESIDENCE (Where deceased lived, if in institution Residence before admision) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
D. C.			13b					13e. STREET AND NUMBER	
								4913 N.H. Ave N.W.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Robert Johnson			Martha Jane Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT Address			
No			577-42-5174			Mrs. Kitty Johnson 4912 N.H. Ave. N.W. D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cerebrovascular disease</u> 1 mo.									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u> 10 yr.									
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>21 April, 1964</u> , to <u>30 May, 1964</u> , that (I) (we) last saw the deceased alive on <u>30 May, 1964</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED						
<u>William A. Wimsatt MD</u>			<u>30 May 69</u>						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
William A. Wimsatt			3415 Hamilton Avenue Hyattsville, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			6-3-69		Riverview Cemetery		Charlottesville Virginia		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Mamie Collins			DATE JUN 5 1969			Charles Judge			
500 University Blvd W Silver Spring Md									

4440

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH		2b HOUR			
Ora B Johnson						Month 5 Day 18 Year 69		2 45 PM			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR			
Female		Caucasian		8-12-92		767-7 YRS.		MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Kentucky		USA				Prince George Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Hyattsville			Hyattsville Nsg Home			Housewife					
13a USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Md.			Pr. Geo.		Brentwood		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3605 Varnum St.		
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
(Unknown)						Belle Mercer					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or (unknown)			16b. SOCIAL SECURITY NO			17 INFORMATION			Address		
						U Conner, RN			2113 Guilford Rd, Hyattsville Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive Heart Failure											
4' DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from 1967 to 5-18, 1969, that (I) (we) lost saw the deceased alive on 5-18, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Walter Kramer						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 5/18/69			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS 8484-16th St. SS. Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial			5/21/1969		Ft. Lincoln Cem.		Colmar Manor, Md.				
24. FUNERAL DIRECTOR						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Nalley's Funeral Home Inc.						Mt. Rainier, Maryland		MAY 23 1969		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or after completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

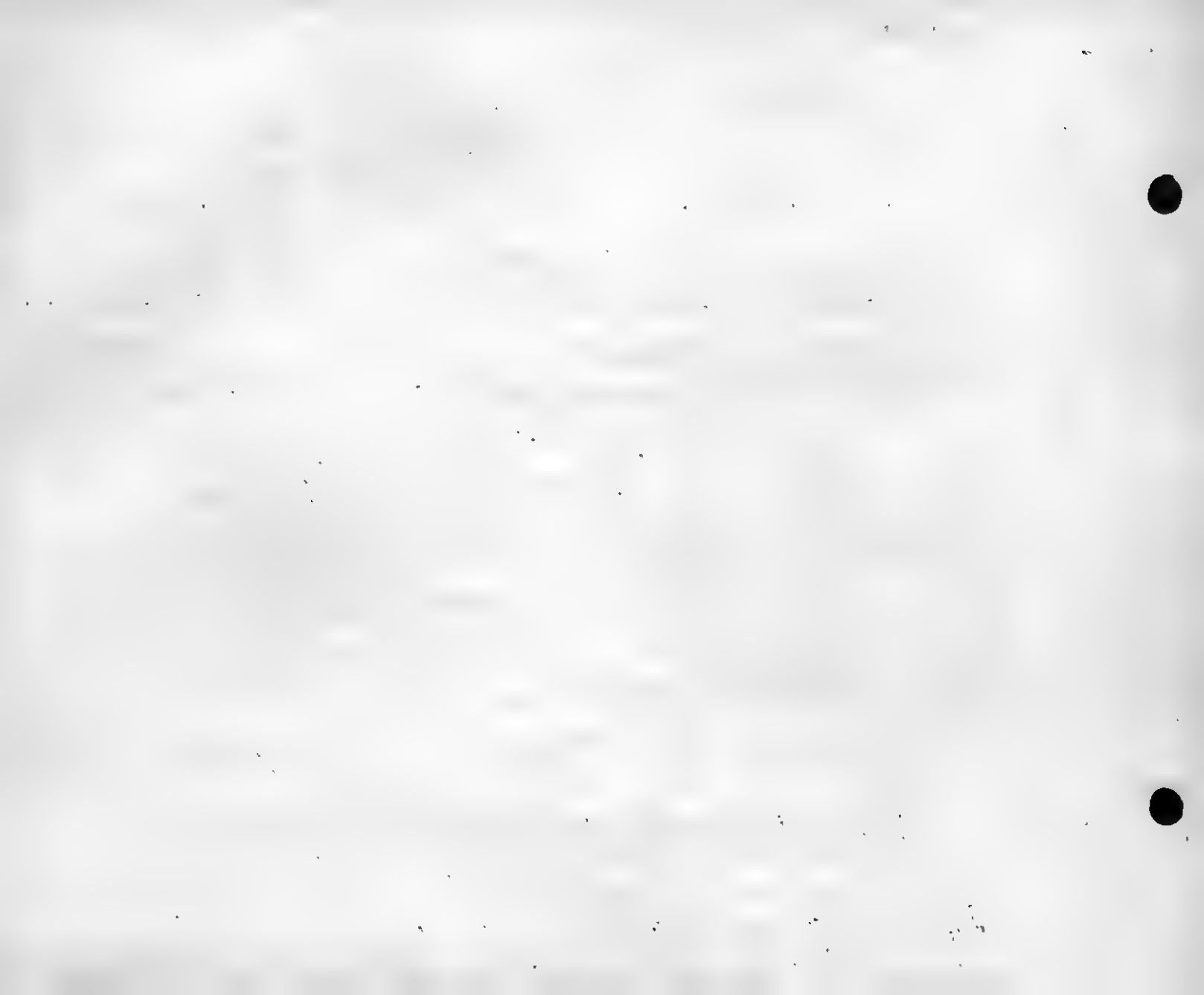
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>Items 1, 13, 14 & 15 filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.</div> <div>7/1/69 kk 07358</div> <div>CERTIFICATE OF DEATH</div> <div>08830</div>											
1. DECEASED NAME (Type or print) Vincent Baby Pierre Marie						2a. DATE OF DEATH Month 5 Day 23 Year 69			2b. HOUR 7:11 PM		
3. SEX Male		4. RACE colored		5. DATE OF BIRTH May 23, 1969			6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 49
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Co. Md					
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE Maryland			13b. COUNTY Prince George's			13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER P.O. Box 128	
14. FATHER'S NAME First Marvin Middle Vincent Last Jones			15. MOTHER'S MAIDEN NAME First Mary Middle Ella Last Morris								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
18. CAUSE OF DEATH (Enter any one cause per line for (a) (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature baby - 7701 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Premature labor - DUE TO, OR AS A CONSEQUENCE OF (c) Ampho Placenta -											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from MAY 23, 1969 , to MAY 23, 1969 , that (I) (we) lost saw the deceased alive on MAY 23, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ricardo Scardascini					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) RICARDO SCARDASCINI					22e. ADDRESS Prince George's Gen. Hospital						
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 6/7/69		23c. NAME OF CEMETERY OR CREMATORY Prince Geo. General Hospital			23d. LOCATION (City or Town) (County) (State) Cheverly, Maryland				
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Administrator					25a. REC'D BY REGISTRAR JUN 10 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				

4489

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07359									
CERTIFICATE OF DEATH									
07353									
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b. HOUR a
Marie			A Joyce			May 30 1969			2:50 M
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		February 8, 1882			87 YRS		HOURS MIN.
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Illinois		United States					Prince George Md.		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Hyattsville			Sacred Heart Home			Housewife			at home
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
District of Columbia			Washington			1959 - 39th Street, N.W.			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Joseph Connors			Anna Germaceau						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17 INFORMANT Address			
No			579-62-7801			Sacred Heart Home, Hyattsville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Failure</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis & Arteriosclerotic Heart Disease</u>									years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>3/18</u> , 19 <u>67</u> , to <u>5/30</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/18</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John W Winkler Jr MD</u> DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5/30/69</u>		
22d. PHYSICIAN'S NAME (Type) <u>JOHN W WINKLER JR</u>					22e. ADDRESS <u>5800 10th PL HYATTSTVILLE, MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		6-4-69		Mt. Olivet Cemetery			Washington D.C.		
24 FUNERAL DIRECTOR <u>W. W. Chamberlain</u> ADDRESS <u>517-11th St. S.E.</u>					25a. RECD BY REGISTRAR <u>JUN 5 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4/25

1

07360

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07354

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
MARY			C	KEATINGE	5 22 69		5:04 AM
3 SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS	
FEMALE	CAUCASION		5-4-88		81 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
D C.	AMERICA				PRINCE GEORGES COUNTY Md		
10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
FORESTVILLE	KENT NURSING HOME		Retired		COMPUTER		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER		
MARYLAND	PRINCE GEORGES	FORESTVILLE			5438 LORRING DRIVE.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
Michael J. Hurley					Nay Lanahan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address	
no		578 44 1318A		D. J. Keating, Son		3438 Lorrington Drive, Forestville, Md. 20028	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)							
4/17/69 DUE TO, OR AS A CONSEQUENCE OF Coronary Insufficiency							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF Coronary Insufficiency							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
Arteriosclerosis cerebrovascular disease cerebral thrombosis Hemiplegia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4-17-1969, to 5-22-1969, that (I) (we) lost saw the deceased alive on 5-21-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Oliver B. Bond				22c DATE SIGNED 5.22.69			
22d PHYSICIAN'S NAME (Type) OLIVER, B. BOND				22e ADDRESS 7420 MARLBORO PIKE FORESTVILLE MARYLAND 20028			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		5/24/69		Mt. Olivet Cemetery		Washington, D. C.	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4303 Suitland Rd., S.E., Suitland, Md., 20023				25a REC'D BY REGISTRAR MAY 27 1969		25b REGISTRAR'S SIGNATURE Charles Judge	

1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07361										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07355									
1 DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
Nathaniel -- King										Month May Day 6 Year 1969										10: p M									
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last b. day)			IF UNDER YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.														
Male			Negro			10/22 /19			49 YRS																				
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
North Carolina			USA						Prince Georges Md.																				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY																				
Glenn Dale, Maryland			Glenn Dale Hospital			Laborer			--																				
13a U.S. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY - M.I.S.? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
STATE						Wash., D.C.						313 Oakdale Street, N.W.																	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME																										
First Middle Last			First Middle Last																										
Louis King			Louise Love																										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT			Address																				
			244-10-7055			Decedent																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic carcinoma, left lung, with metastases															5 mos.														
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
(b) DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
Pulmonary tuberculosis.																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (X) (this hospital) attended the deceased from <u>4/25</u> , 19 <u>68</u> , to <u>5/6</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>5/6</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death																													
22b. SIGNATURE <i>Moe Weiss</i>										DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE SIGNED 5/6/69														
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.										22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal					23b. DATE 4/4/69					23c. NAME OF CEMETERY OR CREMATORIAL BOARD					23d. LOCATION (City or Town) (County) (State) Washington, D. C. <i>Chur.</i>														
24. FUNERAL DIRECTOR <i>Carl F. Oupfuit</i>										25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE <i>Charles J. [unclear]</i>														
										DATE JUN 5 1969																			



07362

CERTIFICATE OF DEATH

07356

1 DECEASED-NAME (Type or print) <u>Female</u>		First <u>Baby</u>		Middle <u>KOSH</u>		Last <u>KOSH</u>		2a DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>1969</u>		2b HOUR <u>10:30</u> P.M.	
3 SEX <u>female</u>		4 RACE <u>colored</u>		5 DATE OF BIRTH <u>May 9 1969</u>		6 AGE (in years lost birthday) <u>YRS.</u>		IF UNDER 1 YEAR MONTHS <u>24</u> DAYS <u>24</u>		IF UNDER 24 HRS HOURS <u>24</u> MIN.	
7a BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Prince George's</u> Md.					
10. CITY OR TOWN <u>Cheverly</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Prince George's Gen. Hosp.</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased admission) <u>Maryland</u>		13b STATE <u>Prince George</u>		13c CITY OR TOWN <u>Laurel</u>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <u>100 9th St</u>			
14. FATHER'S NAME <u>unmarried</u>		First <u>unmarried</u>		Middle <u>unmarried</u>		Last <u>unmarried</u>		15. MOTHER'S MAIDEN NAME <u>Thelma</u>		First <u>Thelma</u> Middle <u>Kosh</u> Last <u>Kosh</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT <u>Thelma</u>		Address <u>Kosh</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dematurity</u> <u>1177X</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (H) (this hospital) attended the deceased from <u>MAY 5</u> , 19 <u>69</u> , to <u>MAY 10</u> , 19 <u>69</u> , that (H) (we) last saw the deceased alive on <u>MAY 10</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Hugh G Clark</u>		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>MAY 10 1969</u>	
22d. PHYSICIAN'S NAME (Type) <u>Hugh G Clark</u>		22e. ADDRESS <u>7309 Riggs Road Hyattsville, Maryland</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>5-17-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pr. George's General Hosp.</u>		23d. LOCATION (City or Town)		(County)		(State)	
24. FUNERAL DIRECTOR <u>Harry W. Penn, Jr., Administrator</u>		ADDRESS		25a. REC'D BY REGISTRAR DATE <u>MAY 22 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. George</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07363

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07357

1 DECEASED NAME (Type or print)		First Baby Boy "B" Middle Last Kosh		2a DATE OF DEATH Month May Day 9, Year 1969		2b HOUR 9:10P M	
3 SEX male		4 RACE colored		5 DATE OF BIRTH May 9, 1969		6 AGE (In years last birthday) YRS. MONTHS DAYS 0 5 18	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md	
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give address) Prince George's Gen. Hosp		12a USUAL OCCUPATION (Kind of work done during most of year if retired) Gen if retired		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland		13b CITY OR TOWN Laurel		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 100 9th street	
14 FATHER'S NAME First Middle Last unmarried		15 MOTHER'S M A DEN NAME First Middle Last The lma Kosh					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prematurity (126.708) 1 hr DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from MAY 5, 1969, to MAY 9, 1969, that (I) (we) last saw the deceased alive on MAY 9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Hugh G. Clark				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) Harry G. Clark				22e. ADDRESS 7309 Riggs Road Hyattsville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 5-16-69		23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. Cheverly, Prince George's, Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Administrator				25a. REC'D BY REGISTRAR MAY 22 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07364

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07358

1. DECEASED NAME (Type or print) Martha E. Kraft			2a. DATE OF DEATH Month May Day 10 Year 1969			2b. HOUR A 10:15 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 9/25/83		6. AGE (In years last birthday) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp		12a. USUAL OCCUPATION (Kind of work done during major part of week, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN St. Pleasant		13d. INSIDE CITY, IN TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6708 F St.	
14. FATHER'S NAME First Henry M. date - Last Jeter			15. MOTHER'S MAIDEN NAME First Sara M. date R Last Rankin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT Paul E. Kraft		Address 6900 C St Seat Pleasant			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 10 years 10 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (I) (the doctor) attended the deceased from Sept , 19 57 , to 5-10 , 19 69 , that (I) (the doctor) last saw the deceased alive on 5-9 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Peter Duus, M.D.		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5/10/69			
22d. PHYSICIAN'S NAME (Type) Peter Duus, M.D.		22e. ADDRESS 6056 Central Ave., Capitol Hgts., Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-13-1969		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City or Town) (County) (State) Washington D. C.			
24. FUNERAL DIRECTOR Robert E. Williams		24b. ADDRESS 308 Spitz Road, Suitland Maryland		25a. REC'D BY REGISTRAR MAY 14 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

5/29/69 kkk DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07365 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07359

1 DECEASED NAME (Type or Print) James Charles		First		Middle		Last Langston		2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 5-18-69		2b HOUR 194:20pm	
3 SEX Male	4 RACE White	5 DATE OF BIRTH 10-21-1950	6 AGE (in years last birthday) 18 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c DATE PROCLAIMED DEAD Month 5 Day 18 Year 69		2d HOUR 6:35pm		2e HOUR	
7a BIRTHPLACE (State or foreign country) Wash., D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's				Md.	
10 CITY OR TOWN OF DEATH Suitland		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Andrews Air Force Base Hosp/		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before adm. sep.) STATE Maryland		13b CITY Prince George's Camp Springs		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7104 Pleasant Hill Drive			
14 FATHER'S NAME William D. Langston		First		Middle		Last		15 MOTHER'S MAIDEN NAME Marion M Lintz		First Middle Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO. (If yes give war or dates of service)		17 INFORMANT Father		ADDRESS Same as 13 above					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day Year 4:15pm 5-18-1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Climbed utility pole							
21a INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) grounds of Crossland High School, Prince George County, Md.		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Kehoe MD		EXAMINER'S NAME (Type) John Kehoe MD		Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
						ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 5-19-69			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 5-22nd 1969		23c NAME OF CEMETERY OR CREMATORY Resurrection		23d LOCATION (City or Town) Clinton Pr. George Md		(County)		(State)	
24. FUNERAL DIRECTOR Robert A. Kettingly		ADDRESS 131 11th St N.E.D.C.		25a REC'D BY REGISTRAR MAY 21 1969		25b REGISTRAR'S SIGNATURE Charles Judge					

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07366	
1 DECEASED NAME (Type or Print) First Middle Last Lattimore Emma Mae										2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2b. HOUR <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM 5 16 19 69 2:30	
3 SEX F	4 RACE Negro	5 DATE OF BIRTH 30 April 1898	6 AGE (In years last birthday) 71 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 5 Day 16 Year 19 69		2d. HOUR 3:10			
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's General				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Prince George		13c. CITY OR TOWN St Pleasant		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7249 Booker Drive.			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 412 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost } (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) unknown APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John Kehoe, M.D., Riverdale				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 5076069			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-20-69		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem.		23d. LOCATION (City or town) (County) (State) Suitland Md					
24. FUNERAL DIRECTOR Rollins F.H.				ADDRESS 4339 Hunt P.I.N.E DC		25a. REC'D BY REGISTRAR MAY 19 1969		25b. REGISTRAR'S SIGNATURE William J. Judge			

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (1)
10M REV 1/69

07367

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07361

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF EST. MATED		Month	Day	Year	2b. HOUR am
Lewis		Lee	Leatherman		5		16	19	69	8:55
3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR am
M	W	10 Aug 1908	60 YRS					5		16
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Maryland		U.S.A.				Prince George				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Cheverly		Prince George Hosp		Machinest		None				
13a. USUAL RES DENCE (Where deceased lived, if institution. Res dence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md		Prince George		Hillside		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1404		51st Ave.
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS
Emory Leatherman		Annie Heerd		No		579-09-9255		Mrs. Anna M. Leatherman		Braddock Hgts. Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Over 6 mos.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?						
Sept 1968		Lung biopsy for carcinoma		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		John Kehoe, M.D., Riverdale		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-16-69
EXAMINER'S NAME (Type)				ADDRESS (Street, city, town, or county)		Cheverly, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		5-19-1969		Resthaven Memorial Gardens		Frederick Co.		Maryland		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Robert E. Dailey & Son		Frederick, Maryland		MAY 22 1969		J. Charles Jones				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07368

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07362

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Betty		Jane		Lowe	Month May Day 7 Year 69		3:32 AM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Female	White		6-29-27		41 YRS		IF UNDER 24 HRS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland		U. S. A.				Prince Georges Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale		Eugene Leland Memorial Hosp.		H. Wife		Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Md.		Mont.		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		4412 Rigley Rd.,
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
John William Best		Ethel May Lowe						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT Address				
no				husband/Medical Record				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CEREBRAL HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>(SPONTANEOUS, CIRCLE OF WILLIS)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>5-6</u> , 19 <u>69</u> , to <u>5-7</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-7</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>DR. KEHOE NOTIFIED</u>								
22a. SIGNATURE		22b. DEGREE		22c. DATE SIGNED				
<u>C. J. Houmann</u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		7 MAY 69				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
C. J. Houmann, M. D.		4400 Queensbury Road, Riverdale, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		May 12, 1969		Parklawn		Rockville Mont. Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Francis H. Barber		Laytonsville, Md.		MAY 12 1969		<u>James J. J...</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13
45M - 1349

07369		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07363			
1. DECEASED-NAME (Type or print)				2a DATE OF DEATH		2b HOUR			
First		Middle		Last		5		Month 23 Day 69 Year 10 30 AM	
Josephine		Lyles							
3 SEX		4 RACE		DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS M.N.	
F		N		8-31-1884		84 YRS.		9 8	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Washington DC		USA				Prince George's		Md	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Clinton		Fine View Gardens							
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
D.C.				Washington				1150-12th St. Apt 614	
14 FATHER'S NAME		15 MOTHER'S M.A.DEN NAME							
First Middle Last		First Middle Last							
John		McCopen		Margaret		Carter			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
no		579664377		Edythe Brent		1905 Lincoln Rd., N.E.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Cardiovascular Collapse</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Melanotic Carcinoma</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
<u>Carcinoma of Breast</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from <u>2/23, 1969</u> to <u>5/23, 1969</u> , that (I) (we) last saw the deceased alive on <u>5/23, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Alfred R. Capin, MD</u>								22c DATE SIGNED	
22d PHYSICIAN'S NAME (Type) <u>ALFRED R. CAPIN, MD</u>								22e ADDRESS <u>CLINTON, MD</u>	
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		5-29-69		Harmony Memorial Park		Landover, Maryland			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Rollins F.H.		4339 Hunt Pl. N.E.		MAY 29 1969		Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2049

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b HOUR	
Odessa			S.		Maitre	May 30, 1969			5:15P M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		
Female		White		8/29/95		73 YRS		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Iowa			U. S. A.				Prince George's Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's Gen. Hosp.			Housewife		Own Home		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Prince George's		Bowie		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12310 Rockledge Dr.	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last	
William					Spaur	Tibitha			Wharton	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b SOCIAL SECURITY NO		17 INFORMANT Address					
no			482 16 8822		Ward J. Maitre Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septic</u>									10 days	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>pancytopenic</u>									10 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>lymphocytic leukemia</u>									1 year	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION		Street or R.F.D. No		City or Town County State		
22a I certify that (I) (the hospital) attended the deceased from <u>Nov 15, 1968</u> to <u>May 30, 1969</u> , that (I) (we) last saw the deceased alive on <u>May 30, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
									May 31, 1969	
22d PHYSICIAN'S NAME (Type)					22e ADDRESS					
Leonard P. Appel, M.D.					3231 Superior Lane, Bowie, Md. 20715					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		6/4/69		Memory Gardens		Concord		California		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Francis Gasch's Sons Hyattsville, Maryland					JUN 4 1969		[Signature]			

FOR STATE HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2-Post-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17-3-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07371

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07365

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED			Month Day Year			2b HOUR							
Vincent			Paul			Mandley			5-2-69			19 4:00am							
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR					
Male		White		8-26-1905		63 YRS.						5 2 69		19 6:06am					
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9 COUNTY OF DEATH							
Washington D.C.				U.S.A.								Prince George's Md							
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY							
Cheverly				Prince George Hospital				Painter				Self							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) - STATE				13b. COUNTY				13c CITY OR TOWN				13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e STREET AND NUMBER			
Maryland				Prince George's				Hillside				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				830 53rd. Avenue			
14 FATHER'S NAME			First Middle Last			15 MOTHER'S MAIDEN NAME			First Middle Last										
Unknown						Agnes						Dean							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO.				17 INFORMANT ADDRESS											
no				578 26 3340				Vincent R. Mandley Same as # 13											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY.																			
IMMEDIATE CAUSE (a) Asphyxia																			
DUE TO, OR AS A CONSEQUENCE OF																			
Aspiration of gastric contents																			
(b) Vomiting -																			
DUE TO, OR AS A CONSEQUENCE OF																			
Associated with acute alcoholism																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a DATE OF OPERATION						19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)											
				19 P.M.															
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE				EXAMINER'S NAME (Type)				22b. DATE SIGNED											
John Kehoe				John Kehoe M.D. Riverdale, Md.				5-2-69											
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)									
Burial				5/5/69		Cedar Hill				Suitland P.G. Md.									
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
Francis Gasch's Sons Hyattsville, Md.						MAY 7 1969				Charles Judge									

released by Mr Keham D. Garlone -

1. DECEASED NAME (Type or print) Beniah Elmer Manuel		First Middle Last		2a. DATE OF DEATH Month May Day 3 Year 1969		2b. HOUR 1A MIN M	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH Oct. 12, 1881		6. AGE (In years last birthday) 87	7. IF UNDER 1 YEAR MONTHS 27 DAYS 27		8. IF UNDER 24 HRS. HOURS 1A MIN M
7a. BIRTHPLACE (State or foreign country) Canada	7b. CITIZEN OF WHAT COUNTRY? Canada	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges				Md
10. CITY OR TOWN OF DEATH Adelphi	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hillhaven Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clergyman		12b. KIND OF BUSINESS OR INDUSTRY Clergy		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Va.	13b. COUNTY Shenandoah	13c. CITY OR TOWN New Market	13d. INSIDE CITY LIMITS YES	13e. STREET AND NUMBER —			
14. FATHER'S NAME First Jacob Middle Manuel Last Manuel		15. MOTHER'S MAIDEN NAME First Phoebe Middle Moore Last Moore					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 223-50-5442		17. INFORMANT Nursing Home Records Address —			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Pul. Embolus DUE TO, OR AS A CONSEQUENCE OF: (b) Gen. Atherosclerosis, Marked Hypertension DUE TO, OR AS A CONSEQUENCE OF: (c) Sec. Pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5/3/69							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR — AM — PM 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. — City or Town — County — State —			
22a. I certify that (I) (this hospital) attended the deceased from 4/21 , 1969, to 5/3 , 1969, that (I) (we) last saw the deceased alive on 4/21 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Howard T. Morse				22c. DATE SIGNED 5/3/69			
22d. PHYSICIAN'S NAME (Type) Howard T. Morse M.D.				22e. ADDRESS 7030 Carroll Ave Takoma Park Md			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE May 6, 1969		23c. NAME OF CEMETERY OR CREMATORY Large Washington Cem.		23d. LOCATION (City or Town) Adelphi (County) JA Geo. (State) Md	
24. FUNERAL DIRECTOR John H. Wright, 254 Carroll, N.W.				25a. REC'D BY REGISTRAR DATE MAY 6 1969		25b. REGISTRAR'S SIGNATURE Charles Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07373

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07367

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
HAROLD E. MARTIN						MAY 20 Day 1969			11:25 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male		White		Unknown		65 YRS.		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Unknown		USA.				Prince George's Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Clinton, Md.			Pine View Gardens			Mechanic			Auto	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTRY			13d. INSIDE CITY, TOWN?		3e. STREET AND NUMBER		
Maryland			P.G.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3733 Wells Ave		
4. FATHER'S NAME			5. MOTHER'S M A DEN NAME							
First Middle Last			First Middle Last							
UNK			UNK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address	
NO			579-05-9563			Chas E. Hibbard			3733 Wells Ave MT Rainier Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Lung</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work						Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 5/24/69 to 5/20/69, that (I) (we) last saw the deceased alive on 5/20/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
ALFRED R. LAPIN, MD								5/20/69		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
ALFRED R. LAPIN, MD			CLINTON, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)	
Cremation			5/20/69			St Lincolns Crematory			Calver Manor Md	
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
NALLEYS Funeral Home			3200 R.D. 2 Calver			MAY 22 1969			[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print) <i>Richard</i>			First Middle Last <i>MARTIN</i>			2a DATE OF DEATH Month <i>5</i> Day <i>20</i> Year <i>69</i>			2b HOUR <i>1:55</i> A M			
3 SEX <i>M</i>		4 RACE <i>W</i>		5 DATE OF BIRTH <i>8/6/1906</i>			6 AGE (In years last birthday) <i>62</i> YRS.		IF UNDER YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>Michigan</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <i>Prince George's</i> Md					
10 CITY OR TOWN OF DEATH <i>Clinton</i>		11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) <i>Funeral Home</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Watch maker</i>			12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD</i>		13b COUNTY <i>Charles</i>		13c CITY OR TOWN <i>La Plata</i>		13d INS. DE. CITY, TOWN, OR VILLAGE YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>Line Street</i>				
14 FATHER'S NAME First Middle Last <i>Unknown</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>Marquerite Weaver</i>									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) <i>Unknown</i>			16b SOCIAL SECURITY NO. <i>Unknown</i>			17 INFORMANT <i>Lillian T. Martin - La Plata, Md</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Cerebrovascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>2/18/59</i> , 19 <i>59</i> , to <i>5/20</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5/20</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Alfred R. Lippman</i>						22c. DATE SIGNED <i>May 22, 1969</i>						
22d. PHYSICIAN'S NAME (Type) <i>ALFRED R. LIPPMAN</i>						22e. ADDRESS <i>CLINTON, MD</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>May 22, 69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Joseph's Memorial Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Clinton, MD</i>						
24. FUNERAL DIRECTOR <i>Michael Funeral Home, Inc. - La Plata</i>						25. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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Continued on page 4

MEDICAL CERTIFICATION

07375		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07369	
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
Martha H. May					May Month 22 Day 1969 Year		5:30 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years)	IF UNDER 1 YEAR
Female		White		25 July 1883		85 (in day)	MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Ohio		U. S. A.				Pr. Geo. Prince George's Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work week, if even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Hyattsville		3514 Longfellow St.		House wife		Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Pr. Geo.		Hyattsville		3514 Longfellow Street	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S M.A.DEN NAME		First Middle Last
Frederick			Schumacher		Elizabeth		Benecke
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address	
No		None		Joan E. May		Same as # 13 Daughter	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))		PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		VIRAL GASTRO-ENTERITIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		GENERALIZED ARTERIOSCLEROSIS & OLD CEREBRO-VASCULAR ACCIDENT					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1952 to May 22, 1969, that (I) (we) last saw the deceased alive on 12-20-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)			
R. S. Fleischer		5-22-69		RONALD S. FLEISHER, M.D.			
22e. ADDRESS		22f. ADDRESS		22g. ADDRESS			
744 R. 1665 Rd		744 R. 1665 Rd		744 R. 1665 Rd HYATTVILLE, Md.			
23a. BURIAL CREMATION		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		5/24/69		Ft. Lincoln Ceme.		Colmar Manor Pr. Geo. Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis Gasch's Sons		Hyattsville, Md.		MAY 23 1969		Francis Gasch	

FOR STATE
HEALTH DEPT.

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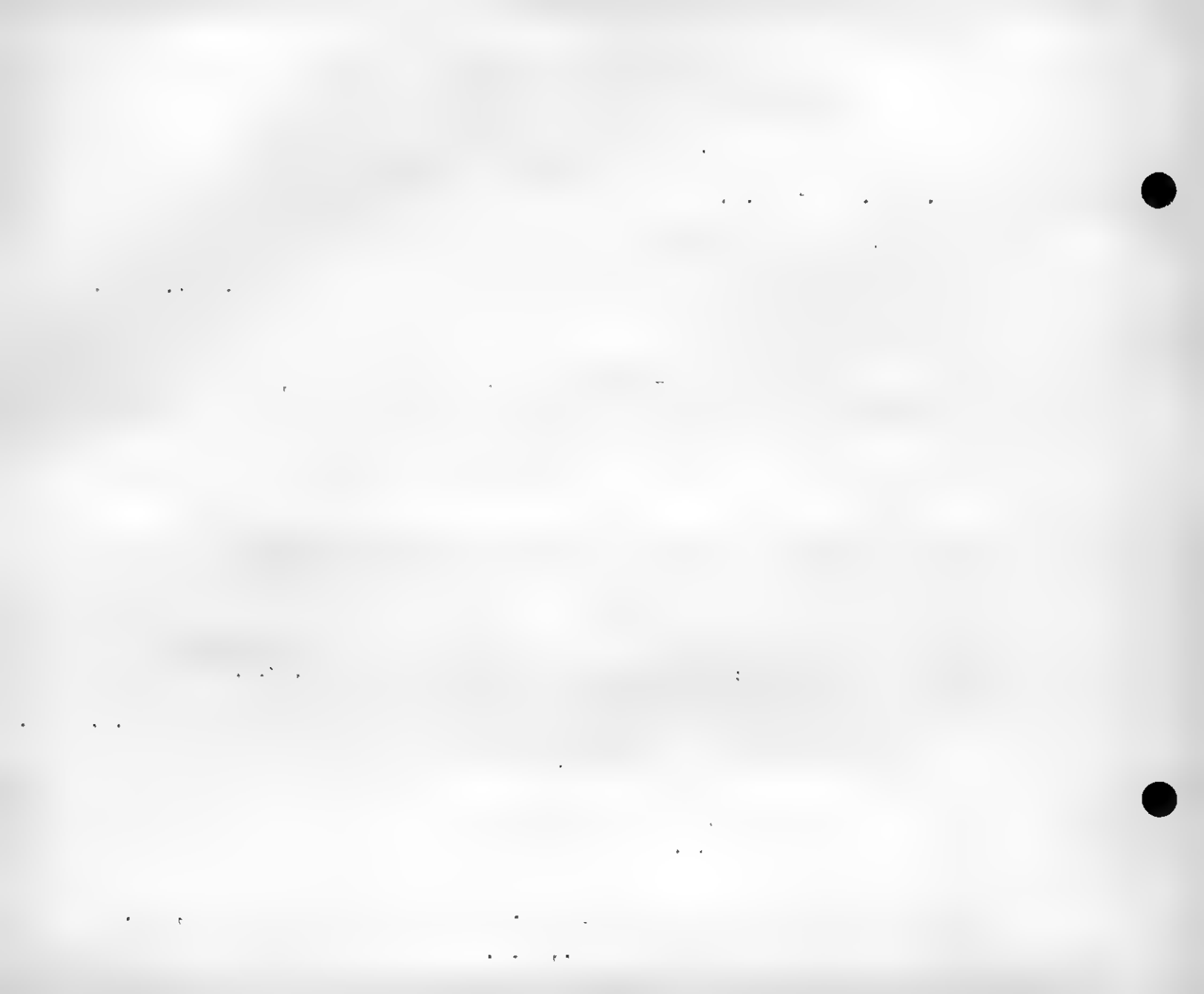
07376

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07370

1. DECEASED NAME (Type or Print)		First		Middle		Last		McPHERSON McPherson		2a DATE KNOWN OF DEATH		Month		Day		Year		2b HOUR	
Stanley										5		30		19		69		9:30 A.M.	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER YEAR		8 UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month		Day		Year		2d HOUR	
M	W	2 Aug., 1952		16 YRS		MONTHS		DAYS		5		30		19		69		9:40 A.M.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH											
No. Car.		U.S.A.		WIDOWED		DIVORCED		Prince George											
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY													
Cheverly		Prince George Hosp		Student															
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS?		13e STREET AND NUMBER											
District of Columbia		Washington		YES		NO		6400 E. St., N.E.,											
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last					
Joseph McPherson								Elva Johnson											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS													
(Yes, no, or unknown)		577-74-0711		Mrs. Elva McPherson; Same as #13 above															
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Laceration of brain		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
816.0		DUE TO, OR AS A CONSEQUENCE OF		Trauma auto Accident		Minutes													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF															
		(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES		NO											
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)															
		8:30 AM 5 30 69		Driver of car which ran off rd at 84th and Sheriff Rd. P.G. Co															
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No		City or Town		County		State									
NOT WHILE AT WORK		Street		Sheriff Rd		P.G.		Md.											
22a I certify that I took charge of the remains described above, held an autopsy, inspection, inquiry, and in my opinion death resulted from.		Natural causes		Accident		Suicide		Homicide		Undetermined manner									
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b DATE SIGNED															
John Kehoe, M.D., Riverdale				5-31-69															
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)									
Burial		6/4/69		Harmony Mem. Park		Highland Park, Md.													
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE													
Robert G. McGuire		1820 9th St., N.W.		JUN 5 1969		H. Chas. Judge													



**FOR STATE
HEALTH DEPT.**

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07377

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07371

1 DECEASED NAME (Type or Print) Charles Melvin Meador III			2a DATE KNOWN OF DEATH Month Day Year 5-1-69 1912:30am			2b HOUR
3 SEX Male	4 RACE White	5 DATE OF BIRTH 11-12-1951	6 AGE (In years last birthday) 17 YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2c DATE PRONOUNCED DEAD Month Day Year 5 1 69 1912:41am
7a BIRTHPLACE (State or foreign country) Washington D C		7b CITIZEN OF WHAT COUNTRY? U S A		9 COUNTY OF DEATH Prince George's Md		
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Painting co		12b KIND OF BUSINESS OR INDUSTRY Painting
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Maryland		13b COUNTY Prince George's		13c CITY OR TOWN Hyattsville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME Charles M Meador jr		15 MOTHER'S MAIDEN NAME Margaret J Powers		13e STREET AND NUMBER 7007 Farragut Street		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO 212 54 6766		17 INFORMANT Charles M Meador Jr		
				ADDRESS Hyattsville Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain c120 DUE TO, OR AS A CONSEQUENCE OF Skull fracture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Trauma - auto accident DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 12:29am 5-1- 1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) Driver of car involved in collision		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 7400 block Annapolis Rd., Glen Ridge, Prince George Co., Md.		21f LOCATION Street or R.F.D. No City or Town County State		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD		22b DATE SIGNED 5-2-69		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town or county)		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE May 3, 1969		23c NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24 FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a REC'D BY REGISTRAR DATE MAY 5 1969
						25b REGISTRAR'S SIGNATURE Charles J. Jones



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07378

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07372

1. DECEASED-NAME (Type or print) GEORGE HAMILTON MILES			2a. DATE OF DEATH Month 5 Day 6 Year 69			2b. HOUR 5 A. M.				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH AUG. 4 - 1925		6. AGE (in years last birthday) 43 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE Md.				
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince Georges Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PRINTER		12b. KIND OF BUSINESS OR INDUSTRY PRINTING				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.			13b. COUNTY PRINCE GEORGE		13c. CITY OR TOWN CLINTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6108 WOODLAND LA.	
14. FATHER'S NAME First Middle Last GEORGE THOMAS MILES			15. MOTHER'S MAIDEN NAME First Middle Last GLADYS B. BARBER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES (If yes give war or dates of service) 1943 - MAR - APR			16b. SOCIAL SECURITY NO. 578-28-773		17. INFORMANT ROSINA E. MILES (ITEM 13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF HYPERTENSIVE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost ATHEROSCLEROTIC CV DISEASE > 1 yr. (b) ATHEROSCLEROTIC CV DISEASE DUE TO, OR AS A CONSEQUENCE OF RHEUMATIC HD: AORTIC INSUFFIC. (c) RHEUMATIC HD: AORTIC INSUFFIC.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH > 1 yr.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) OVERWORK, OVERUSE OF "CONTRA" AS SEDATIVE										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from MAY , 19 68 , to DEATH , 19 69 , that (I) (we) last saw the deceased alive on MAY 2 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Robert W. Merkle M.D.					22c. DATE SIGNED 5 MAY 69		22d. PHYSICIAN'S NAME (Type) Robert W. Merkle, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/9/69		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia				
24. FUNERAL DIRECTOR Robert E. Wilhelm, Funeral Home					25a. REC'D BY REGISTRAR MAY 8 1969		25b. REGISTRAR'S SIGNATURE William E. Jones			

✓



FOR STATE
HEALTH DEPT.

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07379

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07373

1. DECEASED NAME (Type or Print) LESTER		First W		Middle MOLER		Last		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> May 8 1969		2b. HOUR 8:50 P.M.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 25 Apr 1923		6. AGE (In years last birthday) 46 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD May 8 1969		2d. HOUR 856 M	
7a. BIRTHPLACE (State or foreign country) S. Dakota		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's						
10. CITY OR TOWN OF DEATH Suitland, Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired USN Chief			12b. KIND OF BUSINESS OR INDUSTRY Admin Asst			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland				13b. COUNTY Suitland		13c. CITY OR TOWN Suitland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4815 Romain Court		
14. FATHER'S NAME EDWARD		First MIDDLE		Last MOLER		15. MOTHER'S MAIDEN NAME HAZEL		First MIDDLE		Last DEAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Mrs Kathleen P. Moler ADDRESS Same as #13c						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) As iritation of gastr'c contents 911X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 8:50 P.M. 5 8 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Vomited and aspirated								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION: Street or R.F.D. No Same as #13		City or Town Portsmouth		County Norfolk		State Va.		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		CHIEF MED. CAL. EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-8-69.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-12-1969		23c. NAME OF CEMETERY OR CREMATORY Olive Branch Cemetery		23d. LOCATION (City or Town) Portsmouth		(County) Norfolk		(State) Va.		
24. FUNERAL DIRECTOR Robert E. Wilhelm 4308 Suitland Road Suitland Maryland						25a. RECD BY REGISTRAR DATE MAY 14 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

07380										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07374																			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																							
1 DECEASED-NAME (Type or Print)										First Middle Last										2a DATE KNOWN OF DEATH										2b HOUR									
Florence Elizabeth Morgan																				5-28-69										19 12:02pm									
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR																									
Female		White		4-8-1910		59 YRS		MONTHS		DAYS		5		28		69		19		12:45pm																			
7a BIRTH-PLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH																											
Maryland				USA								Prince George's				Md																							
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY																											
Cheverly				Prince George Hospital				Housewife																															
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS?				13e STREET AND NUMBER																							
Maryland				Prince George's				Forestville				YES <input type="checkbox"/> NO <input type="checkbox"/>				7818 Marlboro Pike																							
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME																																			
Clarence Zeigler				Mary Shane																																			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO				17 INFORMANT				ADDRESS																											
								Charles E. Morgan				7818 Marlboro Pike																											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 1. DEATH WAS CAUSED BY:																																							
IMMEDIATE CAUSE (a) Metastatic carcinoma																																							
DUE TO, OR AS A CONSEQUENCE OF Carcinoma of uterus										over 2 yrs																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																																							
(b)																																							
DUE TO, OR AS A CONSEQUENCE OF																																							
(c)																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																							
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED?										20 AUTOPSY?																			
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b TIME OF INJURY Month, Day Year										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
										P.M. 19																													
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																							
ACTUAL SIGNATURE										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										22b. DATE SIGNED																			
EXAMINER'S NAME (Type)										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										5-29-69																			
John Kehoe M.D. Riverdale, Md.										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																													
										ADDRESS (Street, city, town, or county)																													
23a BURIAL, CREMATION, REMOVAL (Specify)										23b DATE										23c NAME OF CEMETERY OR CREMATORY										23d LOCATION (City or Town) (County) (State)									
Burial										5-31-1969										Frederick Memorial Cem										Frederick Maryland									
24 FUNERAL DIRECTOR										25a REC'D BY REGISTRAR										25b REGISTRAR'S SIGNATURE																			
Robert E. Wilhelm Funeral Home										DATE JUN 4 1969										P. Chlanda, Judge																			
4308 Suitland Road Suitland Maryland																																							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07381

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07375

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
George L. Mortimer						May 15, 1969			10:45		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS.	
Male		White		2/21/92		80 77 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Washington, D.C.		USA				Prince George's Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USBA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Georges Gen. Hosp.			Plumber			Construction		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY & M 15? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD			Prince George's			Suitland		YES <input type="checkbox"/> NO <input type="checkbox"/>		5500 Shadyside	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Joseph H. Mortimer			Jane Alice Herbert								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT					
yes			1910-1911			1755 Mary Pierce, Step Daughter 5500 Shadyside Avenue, Suitland, Md., 20023					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) — Arteriosclerotic heart disease											
4123 DUE TO, OR AS A CONSEQUENCE OF											
(b) Cardiomegaly											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that (X) this hospital attended the deceased from May 7, 1969, to May 15, 1969, that (X) (we) last saw the deceased alive on May 15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE								DEGREE		22c. DATE SIGNED	
Luis Bentolia								ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Luis Bentolia, M.D.						Prince George's Gen. Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			5/19/69		Cedar Hill Cemetery			Suitland, Maryland, 20023			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
L. Wilhelm Funeral Home 4308 Suitland Road, S.E., Suitland, Md., 20023						MAY 19 1969			Schwartz		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print) <i>Myette</i>			First <i>Myette</i> Middle <i>Maxley</i> Last <i>Maxley</i>			2a. DATE OF DEATH		2b. HOUR		
3. SEX <i>Female</i>			4 RACE <i>WHITE</i>		5 DATE OF BIRTH <i>1/6/1883</i>		6 AGE (in years last birthday) <i>86</i>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>			7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George</i>		10. CITY OR TOWN OF DEATH <i>Laurel Md</i>	
10 CITY OR TOWN OF DEATH <i>Laurel Md</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Magnolia Spaders Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived if instituting a residence before admission) STATE <i>MD</i>			13b. CITY OR TOWN <i>Woods D.C.</i>			13c. INS DE CITY LA 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>1018 Maryland Ave N.E.</i>	
14 FATHER'S NAME First <i>Elmer</i> Middle <i>Moore</i> Last <i>Moore</i>			15 MOTHER'S MAIDEN NAME First <i>Catherine</i> Middle <i>Phelps</i> Last <i>Phelps</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO	
17 INFORMANT <i>Mary Sue 2124 Pitt St</i>			18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1 DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 3 days							
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) <i>Branchial Pneumonia</i> 3 days							
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>10-24, 1967</i> , to <i>5-14, 1969</i> , that (I) (we) last saw the deceased alive on <i>5-14, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>[Signature]</i>			DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <i>5-14-69</i>				
22d. PHYSICIAN'S NAME (Type) <i>Dr. L. Lewitsky</i>			22e. ADDRESS <i>3408 R. I. Lane Mt Rainier Md</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>5-19-1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Hall</i>			23d. LOCATION (City or Town) (County) (State) <i>Farmington Arlington Va</i>	
24. FUNERAL DIRECTOR <i>Mattingly 131-11th St. S.E. Wash D.C.</i>			25. REC'D BY REGISTRAR <i>MAY 19 1969</i>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07383 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07377

1. DECEASED-NAME (Type or Print) James Richard Oates			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year 5-4-69			2b. HOUR 196:16pm		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 4-20-1950	6. AGE (In years last birthday) 19 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month 5 Day 4 Year 69 198:25pm		
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Instrument Man		12b. KIND OF BUSINESS OR INDUSTRY PG County		
13a. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Forestville		3a. INSIDE CITY, IN TS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6001 Surry Square Lane
14. FATHER'S NAME First George E. Middle Oates Last 			15. MOTHER'S MAIDEN NAME First Mary E. Middle Tyrell Last 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. 			17. INFORMANT Frank W. Smith, General Delivery Tall Timbers, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of neck 9229 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 								
19a. DATE OF OPERATION 			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year 6:15pm 5-4- 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Shot by accidental discharge of gun			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f. LOCATION Street or R.F.D. No. same as #13		City or Town County State 		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL EXAMINER'S NAME (Type) John Kehoe MD			M.D. 			22b. DATE SIGNED 5-5-69		
23a. BURIAL, CREMATION, REMOVAL, SPECIFIC Burial			23b. DATE 5/7/69		23c. NAME OF CEMETERY OR CREMATORY Epiphany Church Cemetery		23d. LOCATION (City or Town) (County) (State) Forrestville, Maryland	
24. FUNERAL DIRECTOR Robert F. Wilhelm Funeral Home			ADDRESS 4308 Suitland Rd., S.E., Suitland, Md., 20023			25a. REC'D BY REGISTRAR MAY 8 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) First Middle Last Sarah nmi Oken						2a DATE OF DEATH 5 Month 31 Day 69 Year			2b HOUR 10:35 AM		
3. SEX female		4 RACE white		5. DATE OF BIRTH 1/17/96		6 AGE (In years last birthday) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a BIRTHPLACE (State or foreign country) Russia		7b CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md					
10 CITY OR TOWN OF DEATH Riverdale			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) homemaker			12b KIND OF BUSINESS OR INDUSTRY		
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland D.C. Montgomery			13b CITY OR TOWN Silver Spring			13c COUNTY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			13d STREET AND NUMBER 5024 Ringle St. Home/Arthee Woodland Nursing		
14 FATHER'S NAME First Middle Last Mayer Meyerowitz				15 MOTHER'S MAIDEN NAME First Middle Last not known							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No				16b SOCIAL SECURITY NO 577-20-1876		17 INFORMANT Address GILBERT OKEN 2400 V. AVE. N.W. D.C.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 433.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Essential arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Apr 9 , 19 69 , to May 1 , 19 69 , that (I) (we) lost the deceased alive on May 1 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE L.W. Maltin		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED May 31, 1969					
22d PHYSICIAN'S NAME (Type) L.W. Maltin		22e ADDRESS Riverdale, Md									
23a BIRTH CERTIFICATION (Specify) Born		23b DATE June 1, 1969		23c NAME OF CEMETERY OR CREMATORY Mt. Lebanon Memorial		23d LOCATION (City or Town) (County) (State) Hyattsville, Md					
24. FUNERAL DIRECTOR C.D. Goldberg		ADDRESS Funeral Home		25a REC'D BY REGISTRAR 4217-94		DATE JUN 3 1969		25b REGISTRAR'S SIGNATURE James Judge			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07385

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08863

Items #1 & #3 taken from birth cert.

1. DECEASED-NAME (Type or print) Twin II Ricky Lee			2a. DATE OF DEATH Month Day Year May 10 1969			2b. HOUR 1629 PM	
3. SEX Male		4. RACE CAUCASIAN		5. DATE OF BIRTH May 10, 1969		6. AGE (in years last birthday) YRS MONTHS DAYS 5	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges	
10. CITY OR TOWN OF DEATH Camp Springs		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN District Hts		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 7904 Foster Street							
14. FATHER'S NAME First Middle Last ROBERT LESLIE OLIVER			15. MOTHER'S MAIDEN NAME First Middle Last LINDA JEAN BUZZARD				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Father		Address 7904 Foster St, District Heights	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO, OR AS A CONSEQUENCE OF (b) Hyaline Membrane disease. 5 hrs. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10 May, 1969, to 10 May, 1969, that (I) (we) lost saw the deceased alive on 10 May 1969, and that in (my) (our) opinion a death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John B. Watkins MD		DEGREE PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10 May 69.	
22d. PHYSICIAN'S NAME (Type) JOHN B. WATKINS		22e. ADDRESS Malcolm Grow USAF Hospital Andrews AFBMD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6/13/69		23c. NAME OF CEMETERY OR CREMATORY PUBLIC CREMATION		23d. LOCATION (City or Town) (County) (State) Washington D.C.	
24. FUNERAL DIRECTOR Carl F. Anepka		ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 12 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

07386

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07379

Item 2a Film 413 6/16/69 kk

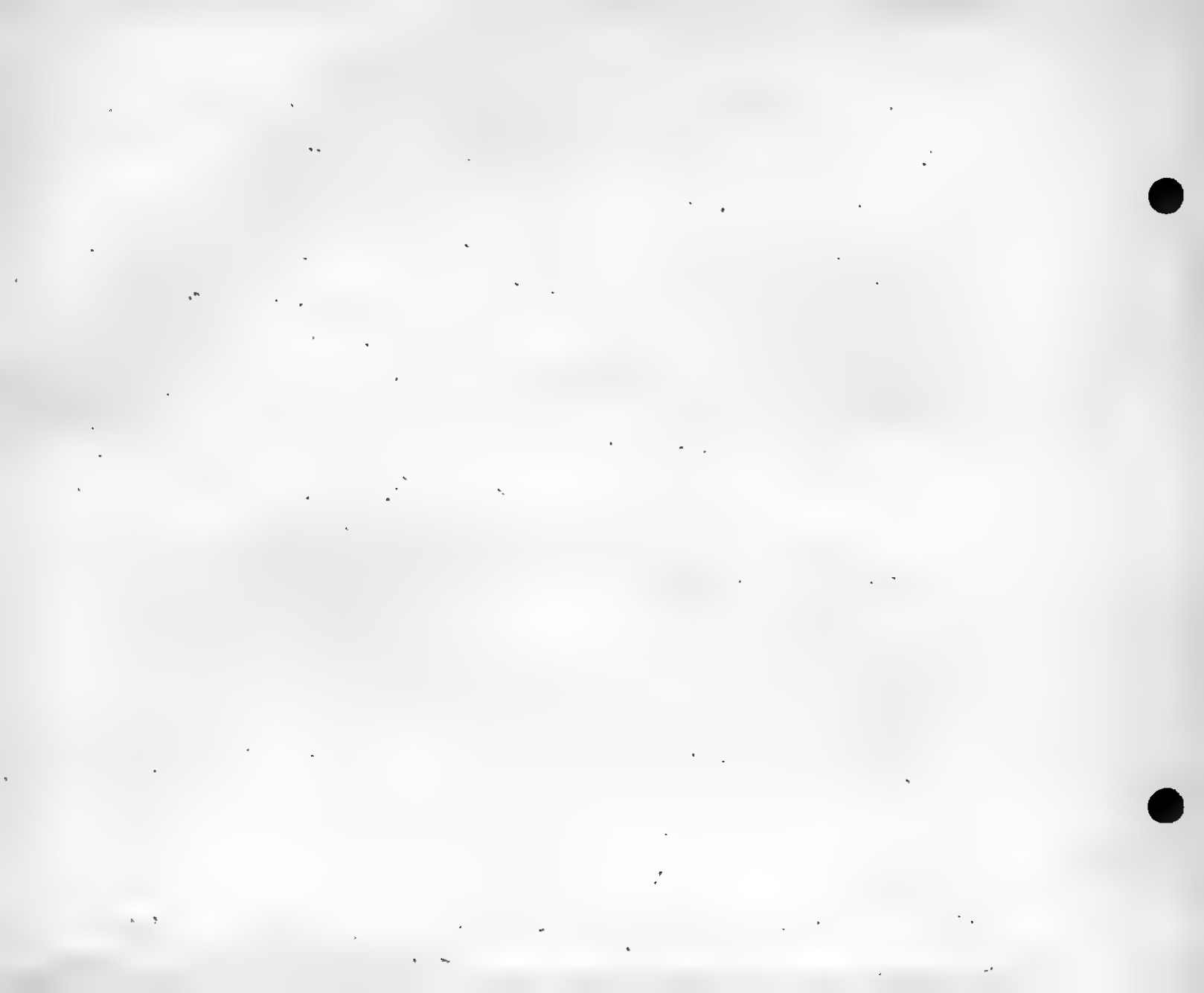
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last WILLIAM N OWENS			2a. DATE OF DEATH Month Day Year MAY 18 1969		2b. HOUR M
3 SEX M	4. RACE W	5. DATE OF BIRTH JULY 14 1895		6. AGE (in years last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) LAUREL MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH PRINCE GEORGE Md.		
10. CITY OR TOWN OF DEATH LAUREL	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BROOKLYN BRIDGE CARPENTER	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CONSTRUCTION		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD	13b. COUNTY P.G.	13c. CITY OR TOWN LAUREL	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER BROOKLYN BRIDGE RD	
14. FATHER'S NAME First Middle Last WILLIAM N. OWENS		15. MOTHER'S MAIDEN NAME First Middle Last IDA E. OWENS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213-05-1914	17. INFORMANT Address MARIE OWENS LAUREL, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C-S-C-V-D 1577 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma prostate DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma colon APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 34m 2 ym 6 mos					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Urinary tract infection					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5/2 , 19 69 , to 5/16 , 19 69 , that (I) (we) last saw the deceased alive on 5/17 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. M. WARREN		DEGREE PHYS	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) J. M. WARREN		22c. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 5/21/69	23c. NAME OF CEMETERY OR CREMATORY Lay Hill Cem.	23d. LOCATION (City or Town) (County) (State) Laurel Md.		
24. FUNERAL DIRECTOR Canadian Funeral Home Laurel	25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07380	
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last HERBERT J. PARKER			2a. DATE OF DEATH Month Day Year 5 29 69			2b. HOUR 6:10 A.M.					
3. SEX M		4. RACE W		5. DATE OF BIRTH 6-3-97		6. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES Md.					
10. CITY OR TOWN OF DEATH ADELPHI		11. NAME OF HOSPITAL OR INST. (If not in hospital give street address) MANOR CARE HOME		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Salesman		12b. KIND OF BUSINESS OR INDUSTRY oil Co.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Wash., D.C.		13b. COUNTY D.C.		13c. CITY OR TOWN Wash., D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4010 - 10th St. N.E.			
14. FATHER'S NAME First Middle Last JOHN Parker			15. MOTHER'S MAIDEN NAME First Middle Last Sarah MILLER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 225-05-0467A		17. INFORMANT Marie Reilly Parker - above ad-		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Brain Syndrome (Wife) dress 6 months DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral neoplasm 6 months DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral infarction 6 months PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Liver Metastases											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from July 19 64 to May 29 19 69 , that (I) (we) last saw the deceased alive on 5/29 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.											
22b. SIGNATURE Edward J. Pacious M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-29-69					
22d. PHYSICIAN'S NAME (Type) Edward J. PACIOUS MD		22e. ADDRESS 915-19th ST. N.W. D.C.									
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 5/31/69		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d. LOCATION (City or Town) (County) (State) Wash., D.C.					
24. FUNERAL DIRECTOR Home Inc.		Address Nalley's Funeral Home Inc.		City Maryland		25a. REC'D BY REGISTRAR JUN 4 1969		25b. SIGNATURE [Signature]			

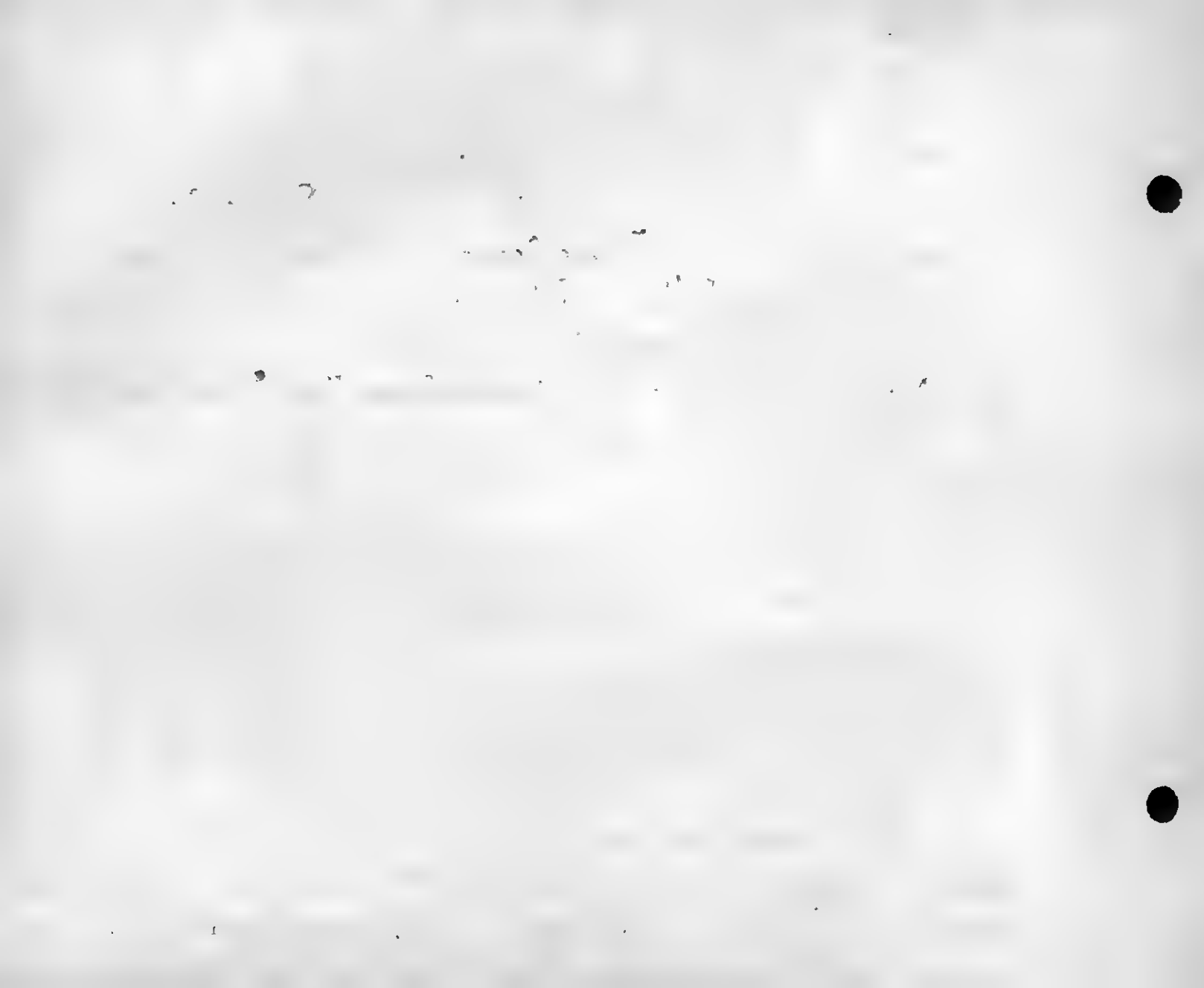
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4/12/69

1

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) Andrew J Pemberton					2a. DATE OF DEATH Month 5 Day 16 Year 1969			2b. HOUR 9:30 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 13th. July 1876		6. AGE (In years last birthday) 92 YRS.		7. UNDER 1 YEAR MONTHS 1 DAYS 1 HOURS 1 MIN 1	
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Storage	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5610 Powhatan Street	
14. FATHER'S NAME First ? Middle Pemberton Last Pemberton			15. MOTHER'S MAIDEN NAME First Unknown Middle Unknown Last Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 578-16-9409		17. INFORMANT Norman Pemberton		Address 2103 Rutland Street Adelphi, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac + Resp. arrest									
DUE TO, OR AS A CONSEQUENCE OF (b) senility									
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) (P) Indirect Inguinal Hernia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 5 Day 12 Year 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. 5/12 City or Town 5/16 County 1969 State 1969					
22a. I certify that (I) (this hospital) attended the deceased from 5/12 , 19 69 , to 5/16 , 19 69 , that (I) (we) last saw the deceased alive on 5/16 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edwin Jensen MD		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5/12/69			
22d. PHYSICIAN'S NAME (Type) Edwin Jensen		22e. ADDRESS Prince George's Hosp.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 5/19/69		23c. NAME OF CEMETERY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.			
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR MAY 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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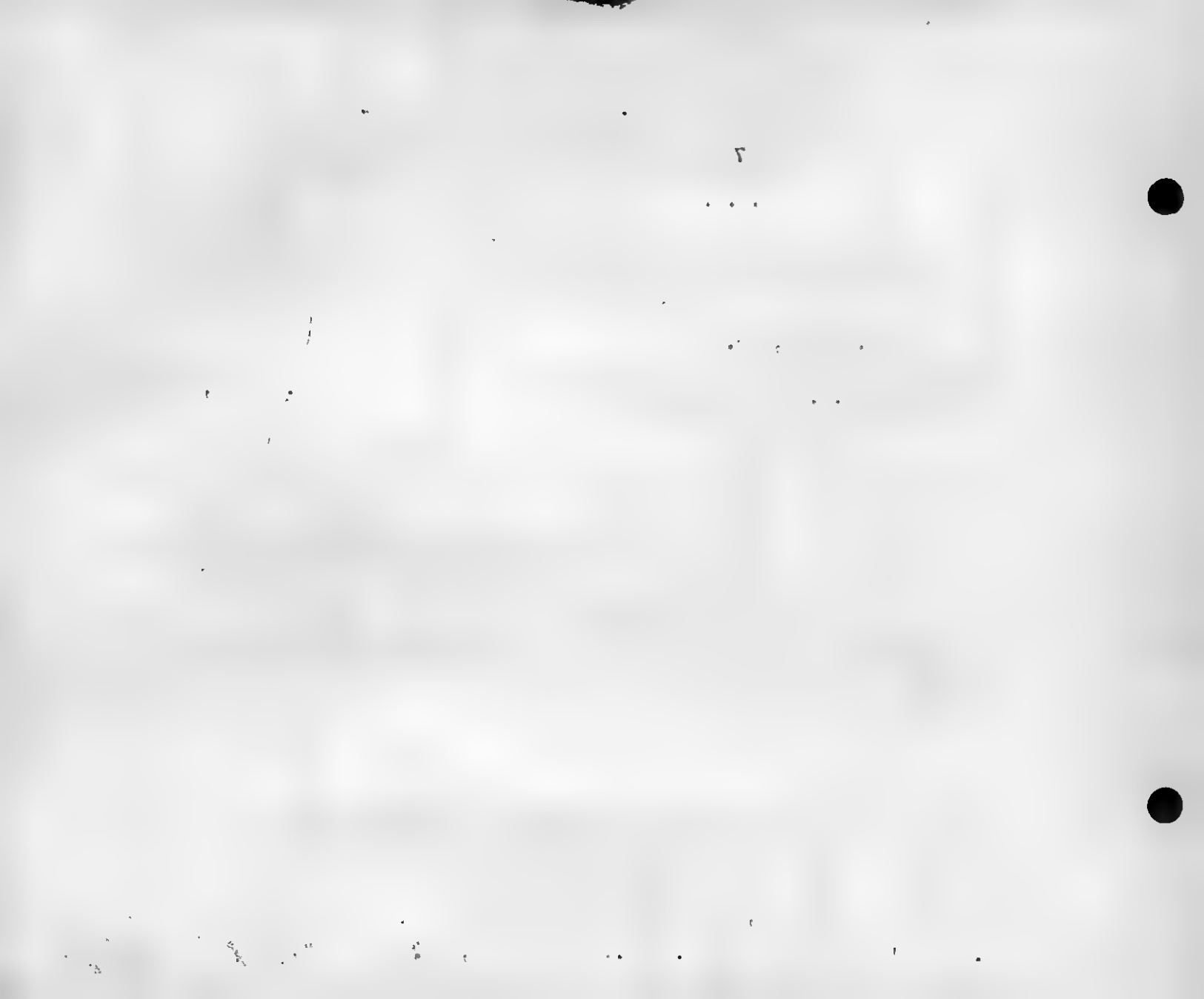
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
Katherine Perrier						5 1 69		1:45A M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS		
Female		White		11-24-96		72 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Austria		U.S.A.				Prince George Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale			Leland Memorial Hospital			HOUSEWIFE		OWN & MANAGE		
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Prince George		New Carrollton				8606 Fremont St.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Karol Horak			unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
unknown			unknown		Marguerite Roosen, 8606 Fremont Street					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intractable CHF</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASERD, severe Kyphoscoliosis, polycythaemia</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>4/22</u> , 19 <u>69</u> , to <u>4/30</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/30</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)						
Verner Albertsen, M.D.		5/1/69		Verner Albertsen						
22e. ADDRESS		22f. ADDRESS								
		4408 Queensbury Rd., Riverdale, Maryland								
23a. BURIAL OR CREMATION <input checked="" type="checkbox"/> REMOVAL TO EXHIBIT		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<input checked="" type="checkbox"/>		May 3, 1969		Calvary Cemetery		Patterson, New Jersey				
24. FUNERAL DIRECTOR		25a. REC'D BY REG. STR.		25b. REG. STR.'S SIGNATURE						
Warner E. Pumphrey, Inc. Silver Spring, Md.		MAY 5 1969		J. J. J. J.						

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Items 18-22a Film 413									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 6-9-69									
Item #2a, Film GL13 6/MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> May 17 1969			2b. HOUR 3:00M
John R. Perry Jr.									
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR 4:48M
Male	White	7-7-26	42 YRS.					5-17-69	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
Ohio		U.S.A.							
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Adelphi			Prince George's			Truck Driver		Nurse	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.			Prince Geo.			Adelphi		9400 Riggs Rd.	
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
John R. Perry, Sr.			Ida Mcglone						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT ADDRESS			
Yes			W.W.11			275 24 9378 Eugene Perry Star Rt. Staut, Ohio			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbon monoxide intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 5-17-19 69		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1, or Part 2, Item 18) Connected rubber hose from exhaust pipe to cab of truck				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 9400 Block Riggs Rd.		21f LOCATION Street or R.F.D. No. City or Town County State Adelphi P.G. Md.				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			5-17-69			
Victor A. Fazekas, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial			May 21, 1969		Bethel Cemetery		Olive Hill Carter Kentucky		
24. FUNERAL DIRECTOR ADDRESS					25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE		
F. Gasch's Sons 4739 Balto. Ave.. Hyattsville, Md.					MAY 21 1969		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>07391</div> <div>CERTIFICATE OF DEATH</div> <div>07384</div>									
1. DECEASED-NAME (Type or print) First Middle Last James G. Phillips					2a. DATE OF DEATH 5-4-69 Month Day Year			2b. HOUR 10:37	
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 10, 1899		6. AGE (In years last birthday) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) N. Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Gen. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Navy Yard		12b. KIND OF BUSINESS OR INDUSTRY Government			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Hyattsville		13d. INS. DE CITY, MHS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3510 55th Ave.	
14. FATHER'S NAME First Middle Last George Phillips			15. MOTHER'S MAIDEN NAME First Middle Last Sophia Zimmerman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes		16b. SOCIAL SECURITY NO. WW 1 & WW 127 09 7884		17. INFORMANT Lillian Phillip		Address Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>3 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION M/R		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED M/R			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>August 1968</u> to <u>5/4/1969</u> , that (I) (we) last saw the deceased alive on <u>April 12 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <u>Dennis J. Hand MD</u>					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5/4/69		
22d. PHYSICIAN'S NAME (Type) DENNIS J. HAND MD					22e. ADDRESS 1600 Connecticut Ave NW Washington DC				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/7/69		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore Baltimore Md.			
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.					25a. REC'D BY REGISTRAR DATE MAY 9 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
07392									
07385									
1. DECEASED-NAME (Type or print)			First MARY Middle E Last REDDINGTON			2a. DATE OF DEATH MAY Month 12 Day 69 Year		2b. HOUR 5:50 M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 6 April 1915		6. AGE (In years last 64 day)		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES Md.			
10. CITY OR TOWN OF DEATH ANDREWS AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital during last 24 hours)		12a. USUAL OCCUPATION (Kind of work done even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before address and state)		13b. CITY OR TOWN PRINCE WILLIAMS		13c. INSIDE CITY LIMITS? GAINSVILLE X NO <input type="checkbox"/>		13e. STREET AND NUMBER RT 1 BOX 250			
14. FATHER'S NAME First JOHN Middle FRANKLIN Last GRAHAM			15. MOTHER'S MAIDEN NAME First CORA Middle LEE Last PAYNE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. 579-07-9733		17. INFORMANT (HUSBAND) Address FRANCIS J REDDINGTON SAME AS ITEM 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory ARREST</u> <u>1951</u> DUE TO, OR AS A CONSEQUENCE OF Candidans, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>METASTATIC (CEREBRAL) CARCINOMA</u> WEEKS DUE TO, OR AS A CONSEQUENCE OF (c) <u>SQUAMOUS CELL CA OF PERINEUM</u> MONTHS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from <u>18 Mar</u> , 19 <u>69</u> , to <u>12 MAY</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>12 May</u> , 19 <u>69</u> , and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Richard Flax</u>		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12 May 69			
22d. PHYSICIAN'S RICHARD FLAX CAPT USAF MC				22e. ADDRESS MALCOLM GROW USAF HOSP ANDREWS AFB					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE May 15 1969		23c. NAME OF CEMETERY OR CREMATORY Stonewall Memory Gard.		23d. LOCATION (City or Town)		(County) (State)	
24. FUNERAL DIRECTOR <u>Baker Funeral Home</u>		ADDRESS Manassas, Va.		25a. RECEIVED BY REGISTRAR DATE MAY 15 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07393

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07386

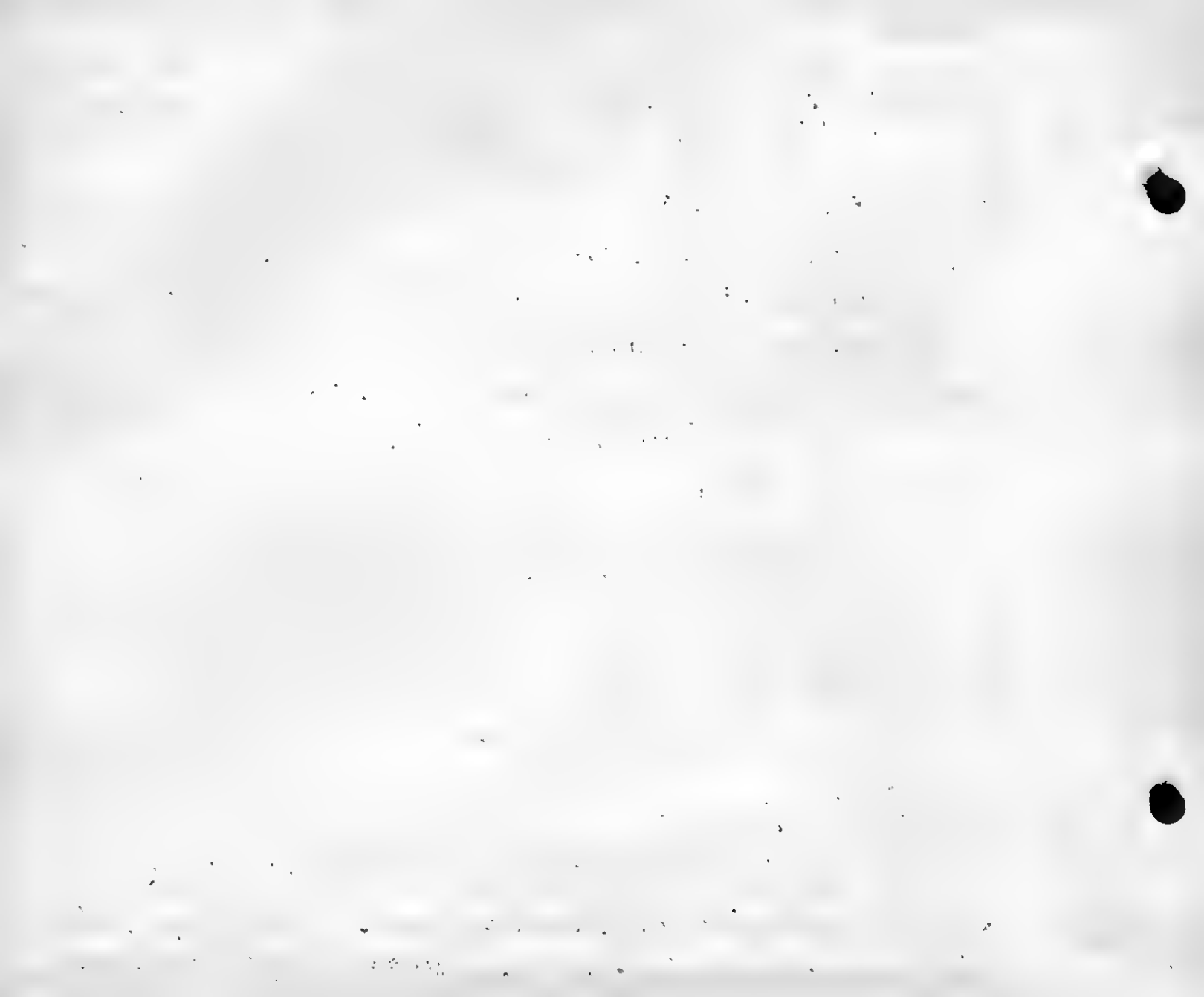
1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH				Month		Day		Year		2b HOUR			
John		W.		Reeve						5		9		19		69		11			
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD				Month		Day		Year		2d TIME	
M	W	8 Sept 1951		17 YRS		MONTHS		DAYS		5				90		19		69		12:35	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH													
Wash. D.C.		U S A		W DOWED		DIVORCED		Prince George													
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY									
Cheverly				Prince George Hosp				Student													
3a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13a. CITY OR TOWN				3d INSIDE CITY LIMITS?				13c. STREET AND NUMBER									
Md.				Forestville				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				3354 Oak Glen Way									
13b. COUNTY				14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME													
Prince George				Clyde S. Reeve				Catherine F. Gates													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT													
NO				None				Clyde S. Reeve,				3354-Oak Glen Way Forestville, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																					
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)																					
816.1 Laceration of brain																					
DUE TO, OR AS A CONSEQUENCE OF																					
Multiple skull fractures																					
DUE TO, OR AS A CONSEQUENCE OF																					
Minutes																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																					
19a. DATE OF OPERATION																					
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																					
20. AUTOPSY?																					
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH																					
21b. TIME OF INJURY Month, Day, Year																					
11:00pm 5 9 19 69																					
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																					
Passenger in car which overturned.																					
21d. INJURY OCCURRED																					
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)																					
21f. LOCATION Street or R.F.D. No																					
City or Town																					
County																					
State																					
St. Rt. 4 near St. Rt. 223 P.G. Md.																					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
22b. DATE SIGNED																					
5-10-69																					
ACTUAL SIGNATURE																					
EXAMINER'S NAME (Type)																					
John Kehoe, M.D., Riverdale																					
23a. BURIAL (CREMATION OR REMOVAL) (Specify)																					
Burial																					
23b. DATE																					
5/13/69																					
23c. NAME OF CEMETERY OR CREMATORY																					
Resurrection Cemetery																					
23d. LOCATION (City or Town) (County) (State)																					
Clinton, Md.																					
24. FUNERAL DIRECTOR																					
ADDRESS																					
Robert E. Wilhelm Funeral Home																					
4303-Suitland, Rd., Suitland, Md.																					
25a. REC'D BY REGISTRAR																					
DATE MAY 14 1969																					
25b. REGISTRAR'S SIGNATURE																					
John Judge																					

1579

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07394		CERTIFICATE OF DEATH						07387	
1. DECEASED NAME (Type or print) First Middle Last MARY (MAX) ELIZABETH RICE						2a. DATE OF DEATH Month Day Year MAY 17 1969		2b. HOUR M	
3. SEX F		4. RACE W		5. DATE OF BIRTH FEB. 21 1899		6. AGE (in years lost birthday) 70 YRS.		F UNDER 1 YEAR MONTHS DAYS F UNDER 24 MRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE Md.			
10. CITY OR TOWN OF DEATH LAUREL		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 702 5TH STREET		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY PR-GEORGE		13c. CITY OR TOWN LAUREL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 702 5TH STREET	
14. FATHER'S NAME First Middle Last WILLIAM BROWER				15. MOTHER'S MAIDEN NAME First Middle Last CELIA NAGLE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO.		17. INFORMANT HAROLD RICE		Address ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Pancreas</u> 1579 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinomatous</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr. 6 mos.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Generalized Arteriosclerosis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1945</u> , 19____, to____, 19____, that (I) (we) last saw the deceased alive on____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>L. A. Warren</u>		DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/19/69			
22d. PHYSICIAN'S NAME (Type) L. A. Warren		22e. ADDRESS Laurel Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/19/69		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City or Town) (County) (State) Laurel Md.			
24. FUNERAL DIRECTOR Donaldson Funeral Home, Laurel		25a. REC'D BY REGISTRAR DATE MAY 22 1969		25b. REGISTRAR'S SIGNATURE Richard Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07395		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07388	
Item 7 Film 412 5/15/69 kk							
1. DECEASED-NAME (Type or print)		First		Middle		Last	
Leon		J.		Risikoff			
3 SEX		4 RACE		5 DATE OF BIRTH		2a. DATE OF DEATH	
Male		White		03-00-94		Month 5 Day 7 Year 69	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Russia		USA				Prince George's Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George's Gen. Hosp.		B4881			
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER	
MD		Prince George's Hyattsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		2214 Banning Place	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.	
First Middle Last		First Middle Last				050-325909	
MENACHEM		RISIKOFF		ETHEL OCONOWITZ			
17 INFORMANT		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
Address		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary heart failure</u>					
2214 Banning Pl. Hyattsville, Md.		(b) <u>ASCVD</u>					
		(c)					
		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
		<u>Diabetes Mellitus Post-traumatic cerebral ventricles of post-hic.</u>					
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) this hospital attended the deceased from April 10, 1969, to May 7, 1969, that (2) we last saw the deceased alive on May 7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (d) (do not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
Robert Deitz, M.D.		Prince George's Plaza, Hyattsville, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
5/9/69		5/9/69		Bethesda Cem.		Elmont, L.I. N.Y.	
24 FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Bernard Dangoor		DATE MAY 9 1969		Charles Judge			

07389

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR			
Edith ADAMS Roberts						DATE MATED <input checked="" type="checkbox"/> 5-26-69			19 3:00am			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years lost birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR	
Female	White	19 NOV 1919	49 YRS	MONTHS	DAYS	HOURS	MIN.	Month Day Year			19 7:00am	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH						
PENNA.		U.S.				Prince George's Md						
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
Cheverly			Prince George Hospital			SCHOOL TEACHER						
13a USUAL RESIDENCE (Where deceased lived, if institution an Residence before admission) - STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			
Maryland			Prince George's			Beltsville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last			13e STREET AND NUMBER			APT.			
CLARENCE J. SURPLUS			MARILLA FAIRLESS			10407A 46th. Ave.			#302			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT			ADDRESS			
No			161142090			RICHARD K. ROBERTS			SAME AS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carbon monoxide intoxication</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carbon monoxide intoxication</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. 1:00PM 5-26 19 69				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Connected nose from exhaust pipe to interior of car				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 455 Place & Samar St.			21f. LOCATION Street or R.F.D. No Beltsville			City or Town Prince Geo.		County Md.		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)					CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED	
John Kehoe MD		Riverdale, Md.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street city town, or county)		5-27-69	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)					
BURIAL		29 MAY 1969		FORT LINCOLN CEM			COLMAR MANOR, MARYLAND					
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
W. W. Chambers Co. Riverdale, Md.								JUN 2 1969		Charles Judge		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07397

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

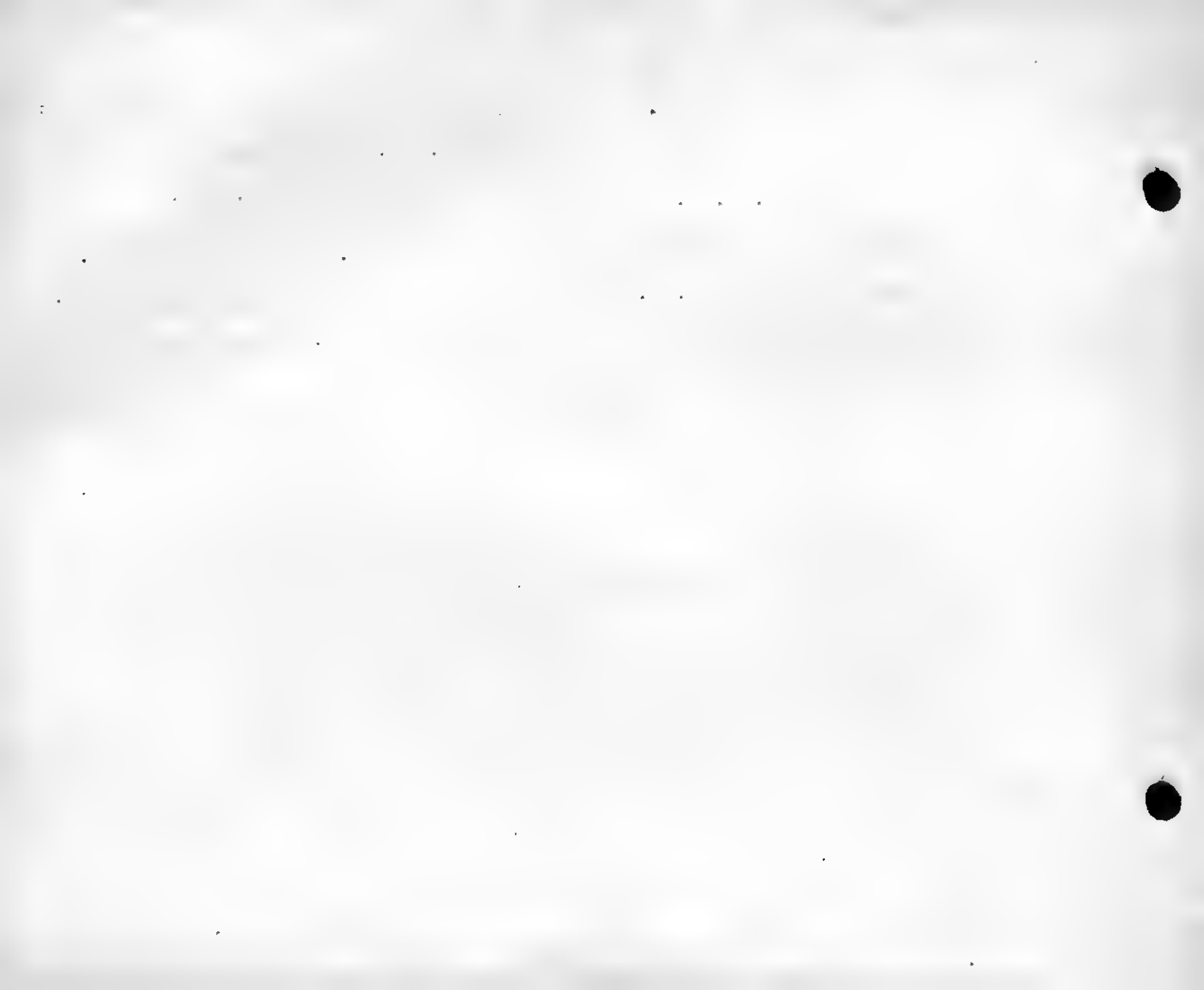
07390

1 DECEASED NAME (Type or Print)			First Martha			Middle A			Last Robinson			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 5-5-69 19 7:18am			2b. HOUR		
3 SEX Female		4 RACE Negro		5 DATE OF BIRTH 8-15-1921		6 AGE (in years last birthday) 41 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD 5 Month 5 Day 69 Year 19 7:45am			2d. HOUR		
7a. BIRTHPLACE (State or foreign country) Char. Co. Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH Prince George's Md					
10 CITY OR TOWN OF DEATH Clinton				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Clinton Medical Center				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland				13b. CITY OR TOWN Prince George's Brandywine				13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER Rt 3, Box 244B					
14 FATHER'S NAME Clarence Lyles			First Middle Last			15 MOTHER'S MAIDEN NAME Mary Margaret Simms			First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or of unknown)				16b. SOCIAL SECURITY NO (If yes give year or dates of service)				17 INFORMANT Bogers Robinson				ADDRESS Same					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral hemothorax DUE TO, OR AS A CONSEQUENCE OF Trauma - auto accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A M 7:15am 5-5- 19 69				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) a fence. Passenger in car which ran off road and hit									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Baden Road, Prince George's County, Maryland				21f. LOCATION Street or RFD No City or Town County State									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED 5-5-69									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE May 8/69				23c. NAME OF CEMETERY OR CREMATORY St. Thomas Ch. Cem. Brandywine, P. Co. Md.				23d. LOCATION (City or Town) (County) (State) Brandywine, P. Co. Md.					
24. FUNERAL DIRECTOR Martelli Adams				ADDRESS Aguasco, Md.				25a. REC'D BY REGISTRAR DATE MAY 12 1969				25b. REGISTRAR'S SIGNATURE Richard L. Jones					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07398										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07391									
Items 5&6 Film G412 5/19/69 kk										CERTIFICATE OF DEATH																			
1 DECEASED NAME (Type or print)					First Middle Last					2a DATE OF DEATH					2b HOUR														
Alida					V. Rogers					May 9 1969					10:40 AM														
3 SEX					4 RACE					5 DATE OF BIRTH					6 AGE (In years last birthday)					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS HOURS MIN				
Female					White					Dec. 18, 1886					86 82 YRS														
7a BIRTHPLACE (State or foreign country)					7b CITIZEN OF WHAT COUNTRY?					8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9 COUNTY OF DEATH														
Missouri					U. S. A.										Pro. Geo.														
10 CITY OR TOWN OF DEATH					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b KIND OF BUSINESS OR INDUSTRY														
Lanham					Magnolia					Ret. Clerk					Dept. Store														
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE					13b COUNTY					13c CITY OR TOWN					13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e STREET AND NUMBER									
Maryland					P. G.					Hyattsville										5801 Queens Chapel Rd.									
14 FATHER'S NAME First Middle Last					15 MOTHER'S MAIDEN NAME First Middle Last																								
Isadore Vanderbeck					Adele J. Duquesne					Roi																			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown					16b SOCIAL SECURITY NO					17 INFORMANT					Address														
No					497 10 6389					William I. Rogers					same as 13														
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac failure															minutes														
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD															months														
DUE TO, OR AS A CONSEQUENCE OF (c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
Senile psychosis																													
19a DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b TIME OF INJURY HOUR A.M. Month Day Year 19					21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)																			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work					21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f LOCATION Street or R.F.D. No. City or Town County State																			
22a I certify that (I) (this hospital) attended the deceased from 4/1/69 to 5/9/69, that (I) (we) lost saw the deceased alive on 5/8/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b SIGNATURE Paul A. DeVore M.D.															22c DATE SIGNED 5-10-69														
22d PHYSICIAN'S NAME (Type) PAUL A. DeVore M.D.															22e ADDRESS 3455 Hamilton St Hyattsville														
23a BURIAL, CREMATION, REMOVAL (Specify)					23b DATE					23c NAME OF CEMETERY OR CREMATORY					23d LOCATION (City or Town) (County) (State)														
Burial					5/14/69					Sun Set Hill Cemetery					Harrisburg, Illinois														
24 FUNERAL DIRECTOR F. Gasch's Son Hyattsville, Maryland															25a REC'D BY REGISTRAR MAY 13 1969					25b REGISTRAR'S SIGNATURE Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

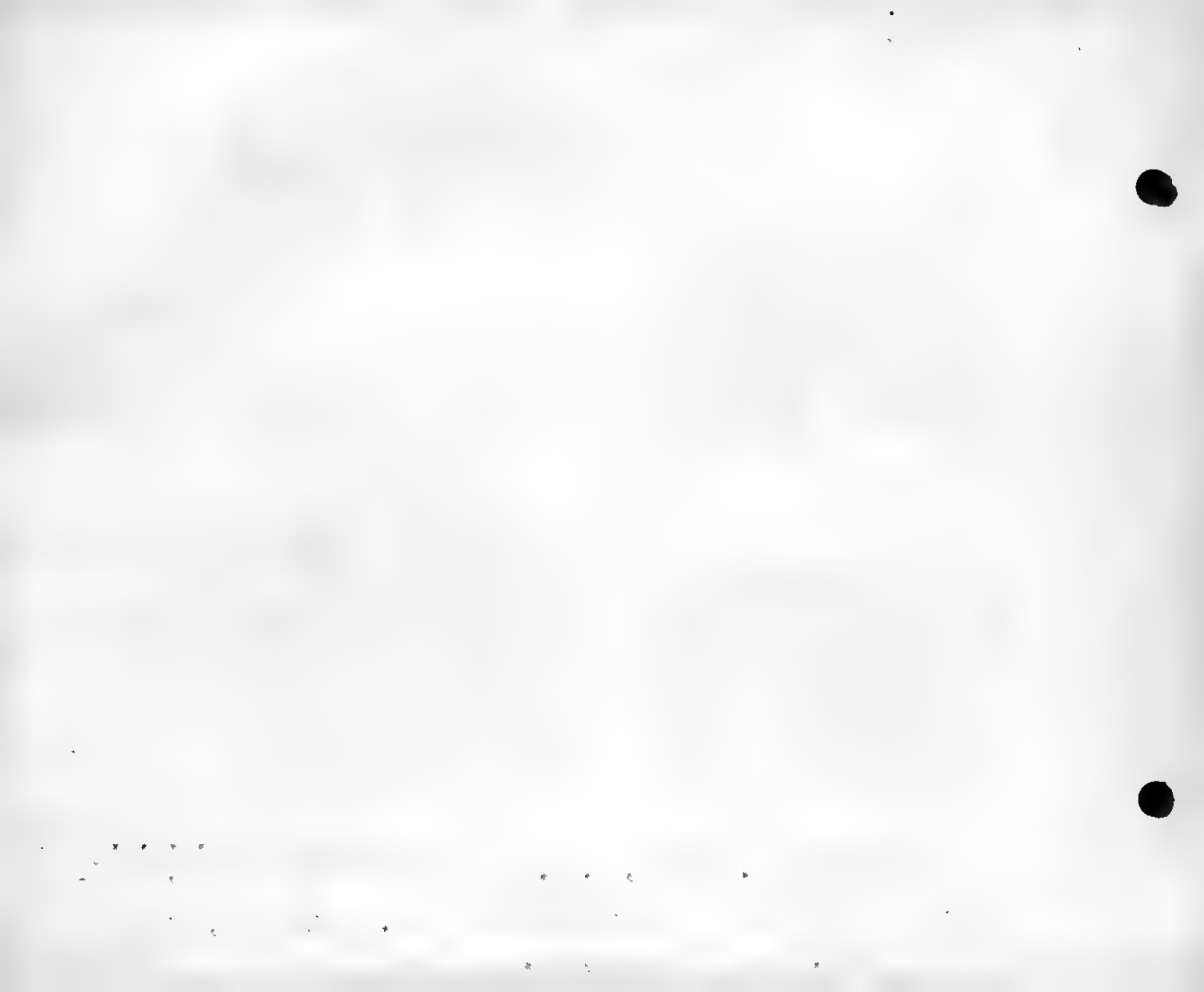
07399

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07392

1. DECEASED NAME (Type or print) First Middle Last LEVON LOUIS ROSKO			2a. DATE OF DEATH Month Day Year MAY 2 1969			2b. HOUR 2014 PM	
3. SEX MALE		4. RACE CAU		5. DATE OF BIRTH 19 JUNE 1914		6. AGE (In years last birthday) 54 YRS	
7a. BIRTHPLACE (State or foreign country) BARTLETSVILLE, OH		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE'S Md.	
10. CITY OR TOWN OF DEATH ANDREWS AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW USAF HOSP		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PRINTER		12b. KIND OF BUSINESS OR INDUSTRY MILITARY	
13a. USUAL RESIDENCE (Where deceased lived, if first tut on: Residence before admission) STATE DELAWARE		13b. COUNTY KENT		13c. CITY OR TOWN DOVER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER LOT 31 LAUREL AND TRAILER PK		14. FATHER'S NAME First Middle Last JOSEPH FELIX		15. MOTHER'S MAIDEN NAME First Middle Last ELIZABETH ROSKO			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown) YES		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 65 515-10-3336		17. INFORMANT WIFE		Address LOT 31 LAUREL AND TRAILER PK DOVER DE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Submucous infection</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 5 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING ETC)		21f. LOCATION Street or RFD No City or Town County State			
22a. I certify that (this hospital) attended the deceased from <u>26/7</u> , 19 <u>69</u> , to <u>2 May</u> , 19 <u>69</u> , that (he) last saw the deceased alive on <u>27 May</u> , 19 <u>69</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>two</u> (did) <u>not</u> view the body after death							
22b. SIGNATURE <u>Geoffrey A. Graham</u>				22c. DATE SIGNED <u>2 May 69</u>			
22d. PHYSICIAN NAME (Type) <u>Geoffrey A. Graham, M. D.</u>				22e. ADDRESS <u>Malcolm Grow U.S. Air Force Hospital, Camp Springs, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5/7/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Ritchie Bros. Upper Marlboro, Md.</u>				25a. REC'D BY REGISTRAR <u>MAY 13 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Wm. J. Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07400

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07393

1 DECEASED NAME (Type or print) Margaret E Ross			2a. DATE OF DEATH Month 5 Day 16 Year 69			2b. HOUR 5:30 AM											
3 SEX Female		4 RACE Negro		5 DATE OF BIRTH 9-19-81		6 AGE (In years last birthday) 87 YRS.		7 UNDER YEAR MONTHS 8 DAYS 7		8 UNDER 24 HRS HOURS 5 MIN. 30							
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md											
10. CITY OR TOWN OF DEATH Forestville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Regent Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY								
13a USJA. RESIDENCE (Where deceased lived, if institution residence before admission) STATE Dist of Columbia			13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4022-15th S.E. #302								
14 FATHER'S NAME First William H. Middle Laurson Last Laurson			15 MOTHER'S MAIDEN NAME First Kate Middle C. Last Carroll			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown NO (If yes give war or dates of service)						16b. SOCIAL SECURITY NO		17 INFORMANT Noretha Lomax - 4022 First St SE		Address #302	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY 402 X IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) unknown DUE TO, OR AS A CONSEQUENCE OF Hypertensive cardiac disease (c) unknown										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If injury, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 4/22 , 19 69 , to May 16 , 19 69 , that (I) (we) last saw the deceased alive on May 16 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.																	
22b. SIGNATURE Henry G. Hailey MD			22c. DATE SIGNED May 16 69			22d. PHYSICIAN'S NAME (Type) HENRY G. HAILEY MD											
22e. ADDRESS 4601 Nichols Ave SE																	
23a. BURIAL/CREMATION REMOVAL (Specify) Burial			23b. DATE 5-20-1969			23c. NAME OF CEMETERY OR CREMATORY Harmony Park Sanderson, Md.			23d. LOCATION (City or Town) (County) (State) Hunt Pl.								
24. FUNERAL DIRECTOR Rollins F.H.			25a. REC'D BY REGISTRAR 4389			25b. REGISTRAR'S SIGNATURE Richard J. [Signature]			DATE MAY 21 1969								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
07401					CERTIFICATE OF DEATH					07394							
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR					
Vincent			H.		Rosson		May			28		1969 6:00 A.M.					
3 SEX			4 RACE			5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male			White			6/8/1902			66		MONTHS		DAYS				
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH								
Virginia			U.S.A.						Prince Georges Md.								
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY								
Glenn Dale			Glenn Dale Hospital			Unknown - Retired			--								
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIM TSP		13e STREET AND NUMBER						
D.C.						Washington			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1402 M Street, N.W.						
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			First		Middle		Last	
Marcellas			Rosson		Alberta		Oates										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT											
Yes			1927 -			Decedent											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Probable myocardial infarction (clinical)</u>												sudden					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u>												years					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive and arteriosclerotic cardiovascular disease</u>												years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
<u>Pulmonary emphysema; chronic bronchitis.</u>																	
19a DATE OF OPERATION			19b CONDIT ON FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
			HOUR A.M. Month Day Year P.M. 19														
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION											
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State											
22a I certify that (X) (this hospital) attended the deceased from <u>3/4/</u> 1966, to <u>5/28/</u> 19 69, that (X) (we) lost saw the deceased alive on <u>5/28/</u> 19 69, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.																	
22b SIGNATURE			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED								
<u>Moe Weiss</u>									5/28/69								
22d. PHYSICIAN'S NAME (Type)			22e ADDRESS														
Moe Weiss, M.D.			Glenn Dale Hospital Glenn Dale, Maryland														
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF ANATOMICAL BOARD			23d CITY OR TOWN (County) (State)								
Removal			6/4/69			ANATOMICAL BOARD			Washington, D.C.								
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE								
<u>Carl F. Oufelt</u>						JUN 5 1969			<u>Charles Judge</u>								

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1. 5 may be retained for your files.

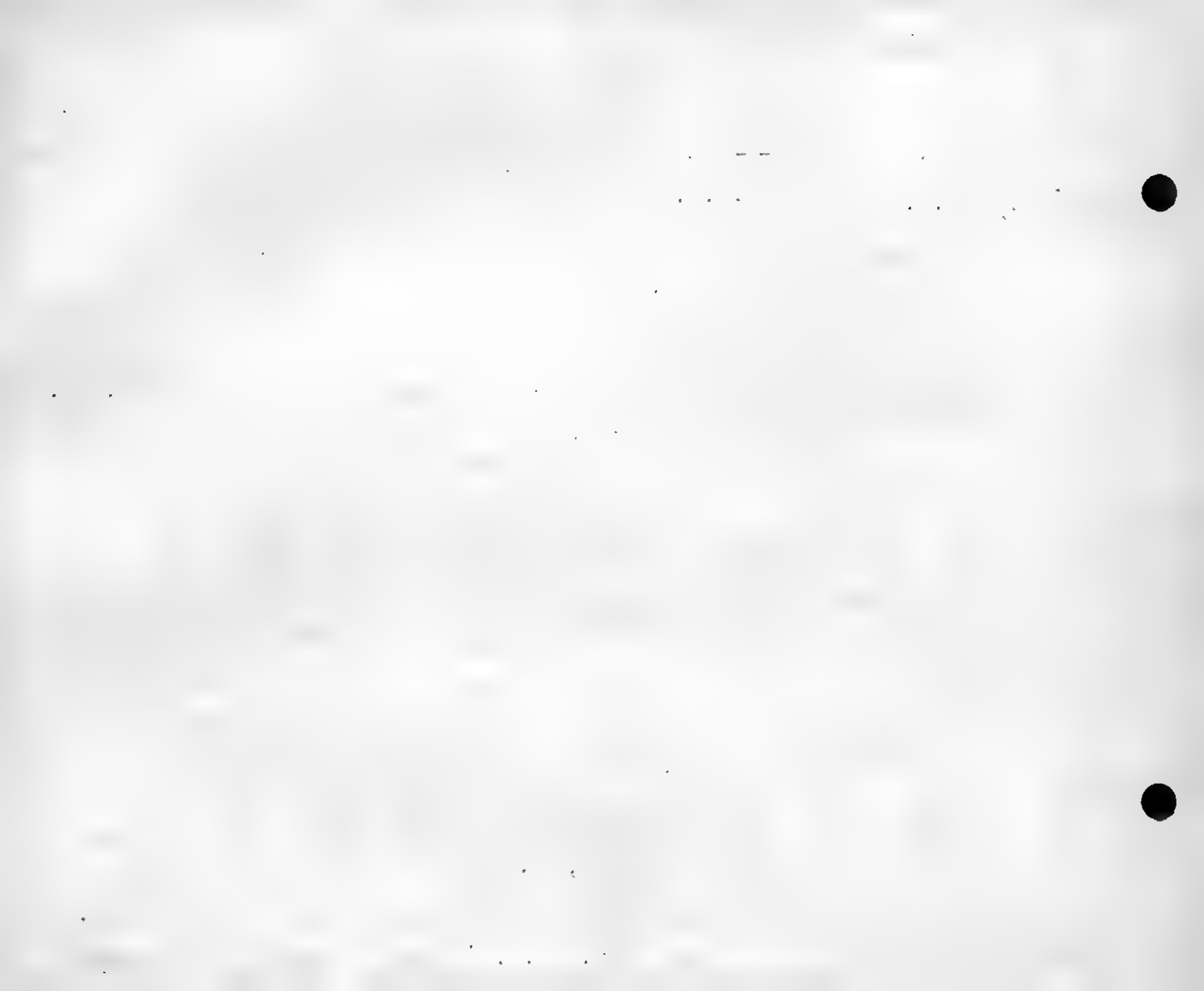
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07402

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07395

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> 5-21-69 12:00am M				2b HOUR	
Janet						Rubin							
3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD				2d HOUR	
Female	White	4-1-1933	36 YRS	MONTHS DAYS		HOURS MIN		5 21 69 19 2:20am M					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
N.Y.C.		U.S.A.						Prince George's					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY			
Bowie		2410 Sudberry Lane				Housewife							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER					
Maryland		Prince George's		Bowie				2410 Sudberry Lane					
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last									
Abraham Chernow				Rose Spitzer									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT				ADDRESS					
				Israel Rubin, Husband,				2810 Sudberry Lane, Bowie, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Atherosclerotic heart disease</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes unknown			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County		State			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		John Kehoe MD Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED			
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		5-21-69			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)							
Burial		5/22/69		King David Mem. Garden		Falls Church, Va.							
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REG STRAR		25b REGISTRAR'S SIGNATURE					
Bernard Danzansky & Sons				3501 14th St. NW, Wash., D.C. 20004		MAY 26 1969		Nicholas Judge					



07403

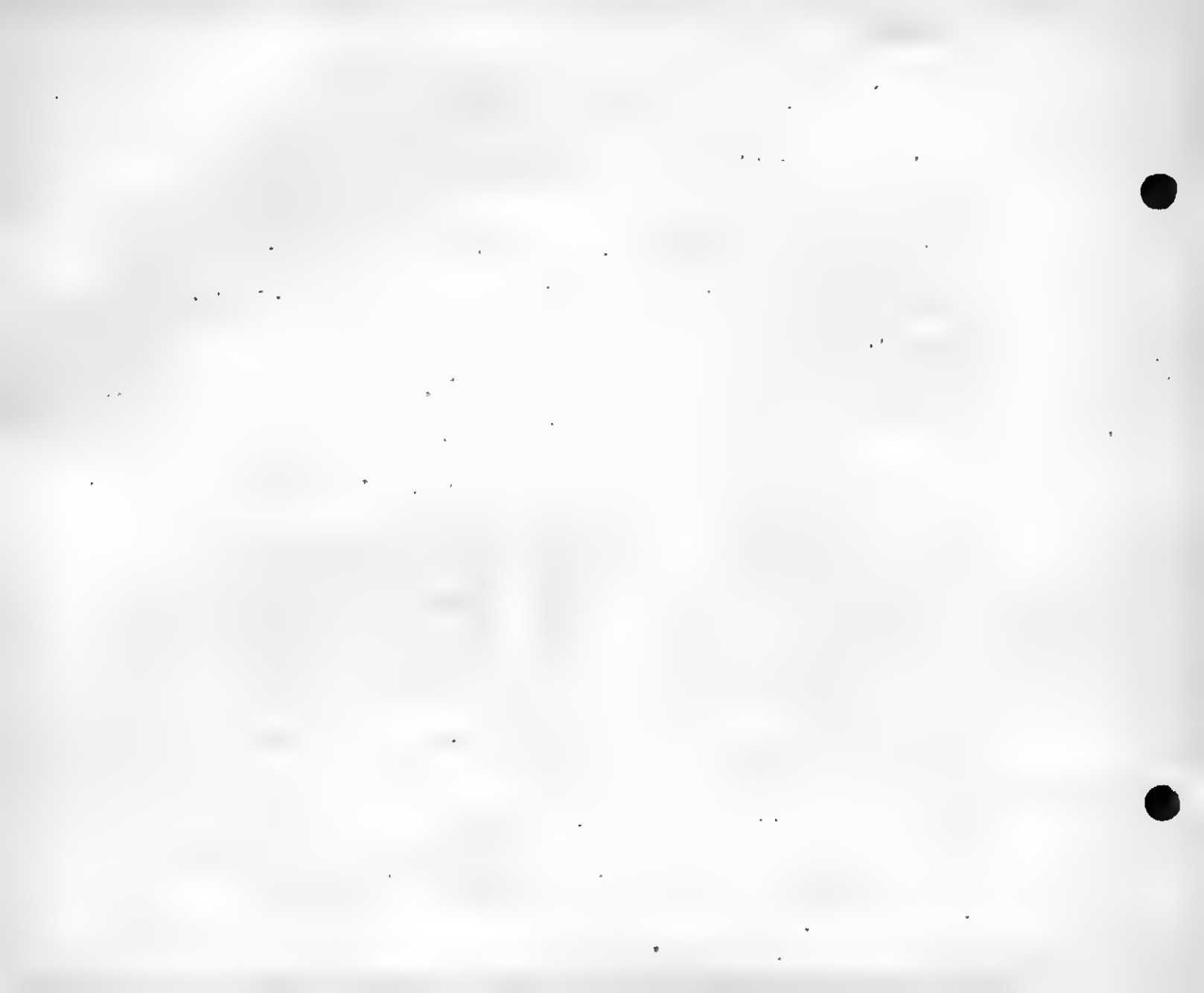
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Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/49

410



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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07404

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07397

1 DECEASED NAME (Type or Print)		First Carl	Middle Cloyce	Last Scott Jr.	2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 5 Month 10 Day 19 Year 69		2b HOUR OF DEATH 1:50 PM
3 SEX M	4 RACE W	5 DATE OF BIRTH 27 Mar 1947	6 AGE (In years last birthday) 22 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month 5 Day 10 Year 19 69	
7a BIRTHPLACE (State or foreign country) N. C.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George	
10 CITY OR TOWN OF DEATH Riverdale		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Hosp		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b KIND OF BUSINESS OR INDUSTRY U. of Md.	
13a admission) STATE Md.		13b COUNTY P.G.		13c CITY OR TOWN Greenbelt		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 8549 Glendale Rd.		14 FATHER'S NAME First Carl Middle C. Last Scott Sr.		15 MOTHER'S MAIDEN NAME First Theresa Middle McNeill Last McNeill		16a WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16b SOCIAL SECURITY NO no		16c. (If yes give war or dates of service)		17. INFORMANT Hospital Records		ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) Laceration of brain							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Trauma Auto Accident							
DUE TO, OR AS A CONSEQUENCE OF							
(b) 5 min.							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year 1:45am 5 10 19 69		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Pedestrian struck by car.			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, school, office, etc.) 9100 Block Baltimore Ave.,		21f LOCATION Street or R.F.D. No College Park		City or Town P. G. County Md. State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.		EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town or county)		22b DATE SIGNED 5-10-69	
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE 5-13-69		23c NAME OF CEMETERY OR CREMATORY McNeill Family Cem.		23d. LOCATION (City or Town) (County) (State) West Jefferson, Ashe, N. C.	
24 FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR MAY 13 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

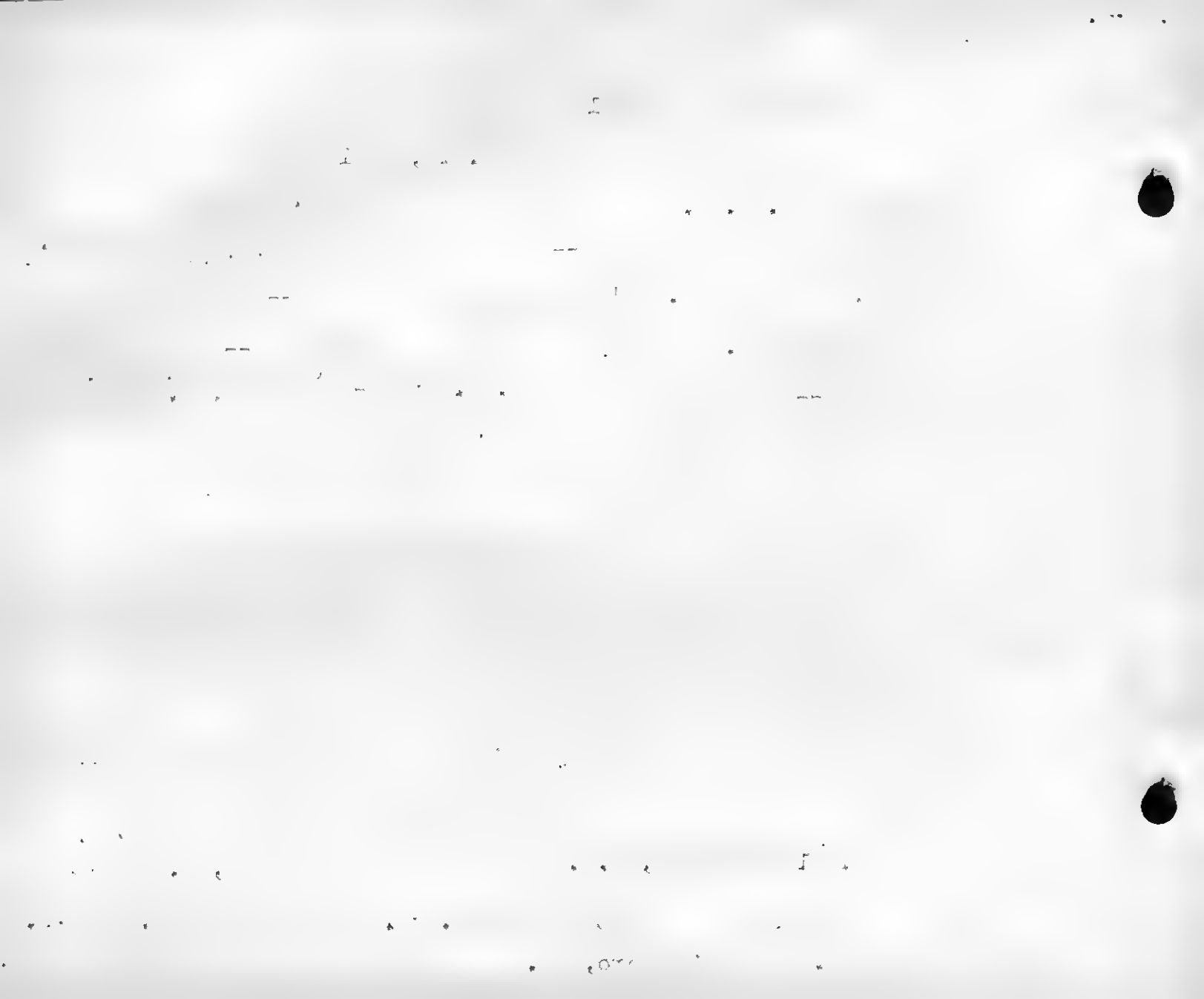
07405

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07398

1 DECEASED-NAME (Type or print) First Middle Last Hattie Idella Selby			2a DATE OF DEATH 5 Month 3 Day 69 Year			2b HOUR 11:30 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH Dec. 18, 1881		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.			
10 CITY OR TOWN OF DEATH Cheltenham		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) --		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret'd School Teacher		12b KIND OF BUSINESS OR INDUSTRY Schools			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Pr. Geo's		13c CITY OR TOWN Cheltenham		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER --	
14. FATHER'S NAME First Middle Last Joseph A. Selby			15 MOTHER'S MAIDEN NAME First Middle Last Martha -- Pyles						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO --		17 INFORMANT Wm. J. Pyles-950 North Hill Road Baltimore, Md. 21218:					
18 CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Syst								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from May, 1964 , to May, 1964 , that (I) (we) last saw the deceased alive on May 5, 1964 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE A. Clark Holmes				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5/3/69			
22d. PHYSICIAN'S NAME (Type) A. Clark Holmes, M.D.				22e. ADDRESS Upper Marlboro, Md. 20870:					
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE 5/5/69		23c NAME OF CEMETERY OR CREMATORY Cheltenham Meth. Cem.		23d LOCATION (City or Town) (County) (State) Cheltenham Pr. Geo Md.			
24 FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.				25a. REG'D BY REGISTRAR MAY 13 1969		25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Carlesburg, Arth. Nelson M. Vigilant Examiner

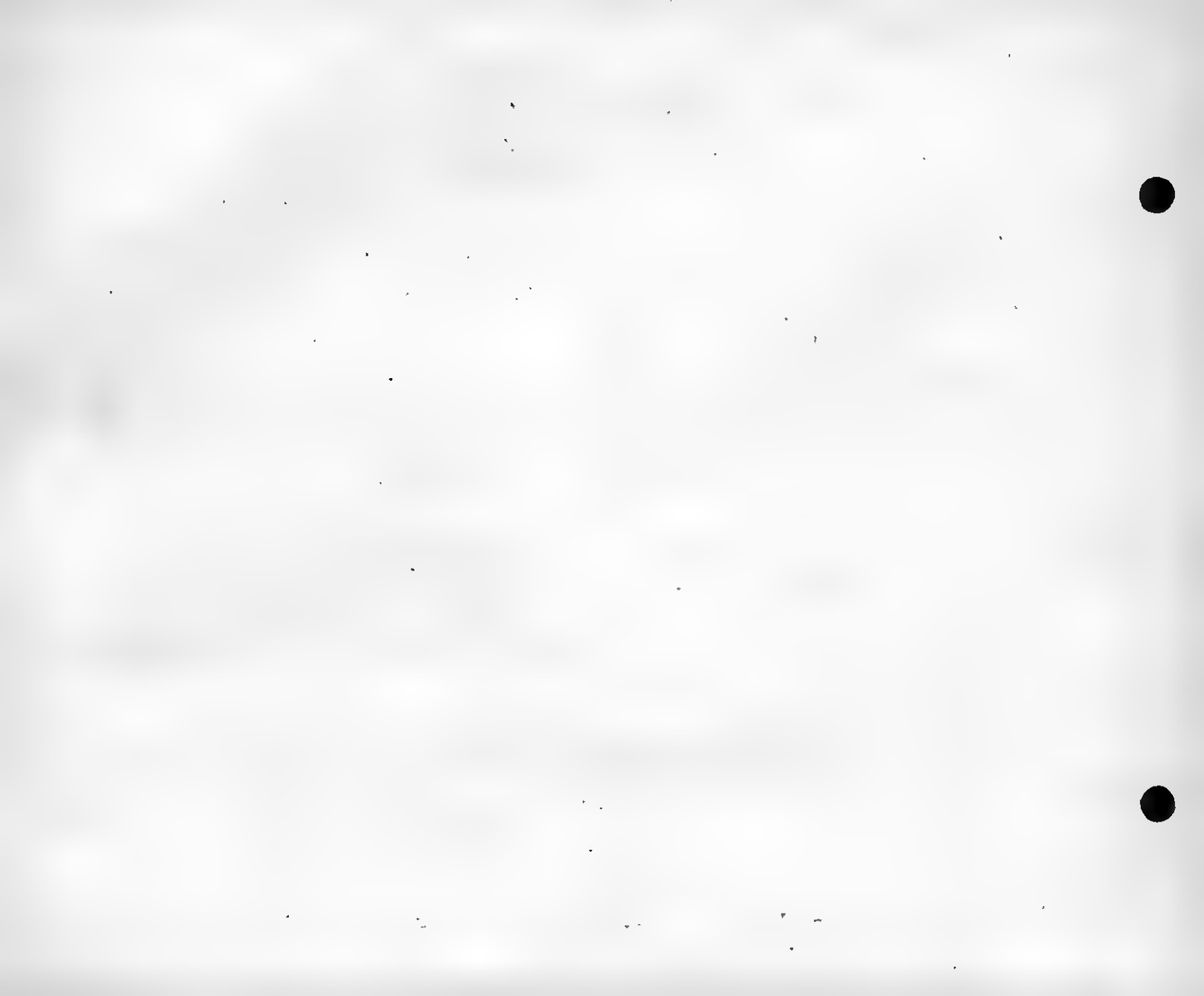
07406

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07399

1. DECEASED-NAME (Type or print) First Middle Last Luther Anderson Senter			2a. DATE OF DEATH 5 Month 3 Day 1969 Year		2b. HOUR 11 P. M.
3 SEX male	4. RACE white	5. DATE OF BIRTH April 7, 1882		6. AGE (In years last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Lincoln Co. N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Prince Georges		Md.			
10. CITY OR TOWN OF DEATH Clinton, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street, address) Clinton Community Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) yard foreman	
12b. KIND OF BUSINESS OR INDUSTRY Quite Master					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY Prince Georges Co. Clinton		13c. CITY OR TOWN Clinton	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5609 Ramblewood Ave.			
14. FATHER'S NAME First Middle Last Epherian - Senter			15. MOTHER'S MAIDEN NAME First Middle Last Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Herbert L. Turner 5609 Ramblewood Ave. Clinton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MIN DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CVD > 6 MOS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) EXTREME OLD AGE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input checked="" type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Nov 1, 1968 to DEATH , that (I) (we) last saw the deceased alive on 2/25/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert E. Wilhelm		22c. DATE SIGNED 5/13/69		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) ROBERT E. WILHELM MD		22e. ADDRESS CLINTON HOSP, CLINTON MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-6-1969		23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery	
23d. LOCATION (City or Town) (County) (State) Charlotte North Carolina					
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland				25a. REC'D BY REGISTRAR MAY 8 1969	
				25b. REGISTRAR'S SIGNATURE Chas. J. Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07407 CERTIFICATE OF DEATH 07400									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Edward J. Sharkey						May 3 1969			2:10 PM
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (n years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS	
Male		Caucasian		6/17/1900		68 YRS.			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH
New York City, N.Y.-U.S.A.									Prince Georges Md
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of work life)			12b KIND OF BUSINESS OR INDUSTRY
Adelphi, Maryland			1801-Metzerott Rd Manor Care, Adelphi			Supt. of Buildings. Real Estate			
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Maryland			Prince Georges-Riverdale			5309 Riverdale Road			Apt 201
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
James J. Sharkey			Martha Shaw						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			
Yes			W.W. I			061-01-1788 A (Manor Care, Adelphi-Adelphi, Maryland)			
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CVA</u> <u>4379</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Arteriosclerosis</u> And (c), if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/19</u> , 19 <u>69</u> , to <u>5/3</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/14</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>Allan Cohan</u>		<u>5/5/69</u>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Allan Cohan, M.D.		Silver Spring, Maryland							
		13515 Georgia Ave Suite 2							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		5/6/69		Baltimore National		Baltimore		Baltimore Md.	
24. FUNERAL DIRECTOR				ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis Gasch's Sons				Hyattsville, Md.		MAY 7 1969		<u>Francis Gasch</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATE ON

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR	
Raymond		L.	Sheets Sr.		5		29	1969	11:20 AM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE	7 UNDER 1 YEAR	8 UNDER 24 HRS	2c DATE PRONOUNCED DEAD		Month	Day	Year	
Male	White	5 May 1942	27	MONTHS	DAYS	5		30	1969	12:00 AM	
7a. BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.			
Penn.		U. S. A.				Prince George					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR (If not in hosp tol give street address)		12a USHA. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY					
Riverdale		Eugene Leland Memorial		Salesman		Coke Cola Co					
13a USUAL RES DENCE (Where deceased lived if institution on Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Md.		Prince George		College Park		NO		9302 Cherry Hill Rd.			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
Woodrow W.		Sheets		Betty		Perry					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		1961-1964		163 34 7055		Shelva J. Sheets Same as #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceratio of brain										Min	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stealing the underlying cause lost											
(b) Trauma motor vehicle accident											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				11:20 PM 5 29 1969				Driver of motorcycle which struck rear of an auto			
21d INJURY OCCURRED				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21f LOCATION Street or R.F.D No City or town County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Street				9500 Block Baltimore Bvd College Park P.G. Md			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		John Kehoe, M.D., Riverdale				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town or county)		5-30-69	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		6/2/69		George Washington		Hyattsville P.G. Md.					
24 FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis Gasch's Sons						Hyattsville, Md.		DATE JUN 4 1969		Thomas Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07409										MARTLAND STATE DEPARTMENT OF HEALTH										07402																																							
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH																																																	
1 DECEASED-NAME (Type or print)					First H.					Middle B.					Last Shirley					2a DATE OF DEATH					2b HOUR																																		
															May					Month					Day					Year					10:15 P.M.																								
3. SEX					Male					4. RACE					Negro					5. DATE OF BIRTH					7/15/18					6. AGE (In years last birthday)					50 YRS					7. UNDER 1 YEAR					8. UNDER 24 HRS														
7a BIRTHPLACE (State or foreign country)					South Carolina					7b CITIZEN OF WHAT COUNTRY?					U.S.A.					8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9 COUNTY OF DEATH										Prince Georges					Md																			
10. CITY OR TOWN OF DEATH					Glenn Dale					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					Glenn Dale Hospital					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					Laborer					12b. KIND OF BUSINESS OR INDUSTRY																													
13a USUAL RESIDENCE (Where deceased lived, if in institution)					D.C.					13b. CITY OR TOWN					Washington					13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e STREET AND NUMBER										622 7th Street, N.E.																								
14 FATHER'S NAME					First					Middle					Last					15 MOTHER'S MAIDEN NAME					First					Middle					Last																								
					Doc										Shirley										Viola										Newman																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)										16b SOCIAL SECURITY NO					248-18-7575					17 INFORMANT					Decedent					Address					Same																								
18. CAUSE OF DEATH (Enter only one cause per item 18a and 18b)										Malignant lymphoma, lymphocytic type (lympho-										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 1 DEATH WAS CAUSED BY										IMMEDIATE CAUSE (a) sarcoma) generalized										5 mo.																																							
2001										DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b)																																																	
										DUE TO, OR AS A CONSEQUENCE OF										(c)																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
Pulmonary tuberculosis																																																											
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED										20a AUTOPSY?										20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										Yes																													
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
										P.M. 19																																																	
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING, ETC)										21f LOCATION Street or R.F.D. No										City or Town										County										State									
22a. I certify that XX (this hospital) attended the deceased from 12/11/19 68, to 5/5/19 69, that he (we) last saw the deceased alive on 5/5/19 69, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (we) (did) not view the body after death.																																																											
22b SIGNATURE										Moe Weiss										DEGREE										ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c DATE SIGNED										5/5/69									
22d. PHYSICIAN'S NAME (Type)										Moe Weiss, M.D.										22e ADDRESS										Glenn Dale Hospital																													
																														Glenn Dale, Maryland																													
23a BURIAL, CREMATION -REMOVAL (Specify)										23b DATE										23c NAME OF CEMETERY OR CREMATORY										23d LOCATION (City or Town)										(County)										(State)									
										5-10-69										Harmony Memorial Park										Landover, Prince George, Md.																													
24 FUNERAL DIRECTOR										ADDRESS										N.W., Wash. DC										25a REC'D BY REGISTRAR										25b REGISTRAR'S SIGNATURE																			
										Hall Bros. Funeral Home 621 Fla., Ave.																				MAY 8 1969																													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

07410

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07403

1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH		2b. HOUR	
Dorothy MARIE Shollenberger				Month Day Year May 12, 1969		4:10	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	7. UNDER 1 YEAR	8. UNDER 24 HRS	
Female	White	12-16-17		51 YRS.	MONTHS DAYS	HOURS MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
WEST VIRGINIA	U.S. AMERICA			Prince George's Md			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly	Prince George's Gen. Hosp.		HOUSEWIFE		HOMEMAKING		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
MD	Prince George's	Suitland	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	7437 Keystone Lane			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
First Middle Last		First Middle Last					
WILLIAM F. MANUEL		MARJORIE PEACHER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address	
NO		UNKNOWN		ROSLYN SHOLLENBERGER		SAME AS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>Acute cerebella infarct</u>							
4122 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Cardiovascular disease</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from May 11, 1969, to May 12, 1969, that (X) (we) last saw the deceased alive on May 12, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Luis Bentolila				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) Luis Bentolila, M.D.				22e. ADDRESS Prince George's Gen. Hosp.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		MAY 15, 1969		FORT LINCOLN CEM.		PRINCE GEORGE'S MARYLAND	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W.W. CHAMBERS CO.				RIVERDALE, MD.		MAY 19 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
07411		Item# Film# G+12 5/21/69 vpw		07404					
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Thelma M. Shorter						Month Day Year May 14, 1969			M
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		7 UNDER 1 YEAR	
Female		Cay.		Feb. 21, 1909		60 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Maryland		U.S.A.				Prince George, Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Brandywine		Rt 1 Box 47		Housework		Domestic			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		P.G.		Brandywine				Rt 1 Box 47	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last John Brooke			First Middle Last Alice Selby						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
No				Jeanne Fox, La Plata, Md. 20646					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Cancer.</u> <u>1829</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Post hysterectomy of for Cancer of Uterus.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pneumonia both sides.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/21, 1968</u> to <u>5/15, 1969</u> , that (I) (we) last saw the deceased alive on <u>5/12, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>N. Bhaduri MD</u>		<u>5/15/69</u>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Niren N. Bhaduri		Waldorf, Maryland 20601							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5-17, 1969		Cedar Hill Cemetery		Suitland, Maryland			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Huntt Funeral Home, Waldorf, Md.				DATE 19 1969		<u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07412					07405				
1. DECEASED-NAME					2a. DATE OF DEATH			2b. HOUR	
First Middle Last					Month Day Year			HOURS MIN.	
Sanford Yokum Simmons					5 18 69			8:00aM	
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7. COUNTY OF DEATH	
Male		caucasian		Dec. 2, 1892		76 YRS.		Prince George's Md.	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Rig. W. Va.		U.S.A.				Prince George's			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Cheverly, Md.		Prince George's Gen. Hosp.		Retired Car Man		B. & O. R.R.			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.		U.S.A.		Brandywine		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Rte. 3 Box 270 Brandywine	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Jethro G. Simmons			Magdalena Pratt						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT Address			
No			No			Mrs. Wm. N. Bingman Brandywine, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the right colon with metastases</u>								Many months	
1530 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)									
<u>Arteriosclerosis heart disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
4/14/69 5/18/69		Carcinoma resection; Rectal fistula		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/26</u> , 19 <u>64</u> , to <u>5/18</u> , 19 <u>64</u> , that <u>4</u> (we) last saw the deceased alive on <u>5/18</u> , 19 <u>64</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <u>4</u> (we) (did) (did not) view the body after death									
22b SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED	
Frederick H. Wilhelm M.D.				M.D.				5/18/64	
22d. PHYSICIAN'S NAME (Type)				22e ADDRESS					
Frederick H. Wilhelm M.D.				6319 Landon Road; Cheverly, Maryland					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		5-21-69		Newhouse Cemetery		Rig. W. Va.		Hardy	
24. FUNERAL DIRECTOR				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Harold W. McKenzie Keyser, W. Va.				MAY 22 1969		Charles Judge			

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13. 13. 13.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07413

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07406

1. DECEASED-NAME (Type or print) First Middle Last Helen W. Simms			2a. DATE OF DEATH Month Day Year May 18, 1969			2b. HOUR 4:35 PM			
3 SEX Female		4. RACE White		5. DATE OF BIRTH 8/27/1895		AGE (In years last birthday) 73 YRS.		IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret.- R.E.A.		12b. KIND OF BUSINESS OR INDUSTRY -			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY Prince George's		13c. CITY OR TOWN Mt. Rainier		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2901 Arundel Rd.	
14. FATHER'S NAME First Middle Last George Warwick			15. MOTHER'S MAIDEN NAME First Middle Last Margaret Drisoll						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 714-03-2698		17. INFORMANT Hazel Wirsching-		Address 6639- 24th Pl., W.Hy., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Acute Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF, (c) <u>Chronic Bronchial Asthma Exacerbation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 week</u> <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 1966, to <u>5-18</u> , 1969, that (I) (we) last saw the deceased alive on <u>5-18</u> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) W. SAKAKI				22e. ADDRESS 6001 Landover Rd. (Clara)					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 5/21/69		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City or Town) (County) (State) Wash., D.C.			
24. FUNERAL DIRECTOR Home Inc.				ADDRESS Mt. Rainier Maryland		25a. REC'D BY REGISTRAR MAY 23 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div> <div>07414</div> <div>07407</div> </div>									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
Annie Louise Simpson						<input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> 5-25-69 11:00am			2b. HOUR
3 SEX	4 RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD	2d. HOUR
Female	White	6-7-1914	54 YRS.					Month 5 Day 25 Year 69 19 12:17 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Md.		U. S. A.				Prince George's Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince George Hospital			Housewife			Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution on Residence before)				13c. CITY OR TOWN		3d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland				Prince George's Oxon Hill		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7891 Locust Lane	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Alvin Lee Moore			Blanche I. Ball						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
no			578 01 3592		Audrey E. Mercillott 5408 Hamilton Street Hyattsville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute hepatitis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>and hemorrhagic pancreatitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>last</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)				
			19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MED. CAL. EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
<i>John Kehoe</i>			John Kehoe MD Riverdale, Md.			ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>		5-26-69	
						DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/28/69		Ft. Lincoln		Colmar Manor P.G. Md.			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Francis Gasch's Sons Hyattsville, Md.			JUN 2 1969			<i>Francis Gasch</i>			

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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07415

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07408

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Ralph Melville Simpson						Month Day Year			2d. HOUR		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	April 2, 1905	64 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year			2d. HOUR
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH		
Maryland			U. S. A.			WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Prince George's Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Cattle Farming			Own Farm		
3a. USUAL RESIDENCE (Where deceased lived, if institut an. Residence before admiss on) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Prince George's			Upper Marlboro			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		
Albert Thomas Simpson			Sarah -- Thomson			No			Same as 13-B		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Mrs. Charlotte L. Simpson Hagen-			13-B			PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary emboli					
						319.7 DUE TO, OR AS A CONSEQUENCE OF					
						Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
						(b) DUE TO, OR AS A CONSEQUENCE OF					
						(c) DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
5-2-69			Subdural hematoma			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			1:24pm 5-2- 1969			Automobile accident					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
			Rosaryville Road, Prince			George County, Maryland					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
John Kehoe			John Kehoe M.D.			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			5-19-69		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			5/20/69			Trinity Cemetery			Upper Marlboro Pr. Geo. Md		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Ritchie Bros. Fun'l Home-			Upper Marlboro Md. 20870:			MAY 23 1969			Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07416		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07409	
CERTIFICATE OF DEATH							
1. DECEASED NAME (Type or print)		First ELIZABETH		Middle SMITH		Last SMITH	
2a. DATE OF DEATH		Month MAY		Day 1		Year 69	
2b. HOUR		P 1:30		M M			
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH 14 Jan 39		6. AGE (In years birthday) 30 YRS	
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES Md.	
10 CITY OR TOWN OF DEATH ANDREWS AFB		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital street address) MALCOLM GROW USAF HOSP		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY NA	
13a. USUAL RESIDENCE (Where deceased address) VIRGINIA		13b. CITY OR TOWN FAIRFAX		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8004 ASHBORO DR	
14 FATHER'S NAME		First JOSEPH		Middle EDWARD		Last OSHMAN	
15 MOTHER'S MAIDEN NAME		First ANNA		Middle EVELYN		Last ETRO	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 193-30-1922		17 INFORMANT (Husband) Donald Smith		Address Same as item # 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis							1-2 mths
DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of colon							10 mths
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Sept , 19 68 , to 1 May , 19 69 , that (I) (we) lost saw the deceased alive on 1 May 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE David Rosenthal				DEGREE ATTENDING <input type="checkbox"/> MED <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYS <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 1 May 69	
22a. PHYSICIAN'S NAME (Type) DAVID ROSENTHAL, MAJ USAF MC				22e. ADDRESS MALCOLM GROW USAF HOSP ANDREWS AFB			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-5-69		23c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery		23d. LOCATION (City or Town) (County) (State) Chesapeake Prince Georges	
24. FUNERAL DIRECTOR W. W. Chamber		ADDRESS 517-115th St. S.E.		25a. REC'D BY REGISTRAR MAY 8 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
07417		CERTIFICATE OF DEATH						07410					
1 DECEASED NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH Month Day Year		2b HOJR P 9:40M		
Harvey			A.		Smith				May 20, 1969				
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
Male		Caucasion		4/5/1904			64 YRS.						
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH				
Va.			U.S.A.						Prince Georges			Md	
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY	
Riverdale,				E. Leland Mem. Hosp.				Steamfitter					
13a USUA. RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Md.			P.G.			Landover					1600 Annapolis Ave.		
14. FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			First Middle Last	
Alonso			W.		Smith				Roxanna			Dozier	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			Address				
No			229-10-7630			Harvey E. Smith			406 Maple St., Manassas, Virginia				
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gastro-Intestinal Bleeding</u>										5 days			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Jejunitis, at Portion</u>										6 days			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
17 May 1969		Gastro-Intestinal Bleeding				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. Month Day Year											
(If either, notify medical examiner)		P.M. 19											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f LOCATION		Street or RFD No.		City or Town		County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>4 May</u> , 1969, to <u>20 May</u> , 1969, that (I) (we) last saw the deceased alive on <u>20 May</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE				DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED			
<u>Thos M. Hutchins</u>										5-20-69			
22d. PHYSICIAN'S NAME (Type)				22e ADDRESS									
Thomas M. Hutchins				7315 Landover Rd. Hyattsville, Md.									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town)		(County)		(State)		
Burial		5/22/69		Ft. Lincoln Cemetery			Bladensburg, Maryland						
24 FUNERAL DIRECTOR						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Robert E. Wilhelm Funeral Home						MAY 26 1969		<u>[Signature]</u>					
4308 Suitland Road, S.E., Suitland, Md., 20023						DATE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07418

CERTIFICATE OF DEATH

07411

1. DECEASED-NAME (Type or print) Clara D. Speight			2a. DATE OF DEATH Month 5 - Day 27 - Year 1969			2b. HOUR 6 P M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 12-20-10		6. AGE (in years last birthday) 58 YRS	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARR ED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md	
10. CITY OR TOWN OF DEATH RIVERDALE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) KELAND MEM HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 4418 Greenwood Road		14. FATHER'S NAME First Middle Last Jonas C. Dilda					
15. MOTHER'S MAIDEN NAME First Middle Last Almeda Killebrew		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO					
16b. SOCIAL SECURITY NO 578202050		17. INFORMANT JAMES L. SPEIGHT, 4504 SAMAR ST. BELTSVILLE, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Cond trans, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) UNKNOWN							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 29 DAYS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) DIABETES MELLITUS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 29 APR. 1969 to 27 MAY 1969 , that (I) (we) last saw the deceased alive on 27 MAY 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C.J. Houmann		DEGREE C.J. HOUMANN M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 27 MAY 1969	
22d. PHYSICIAN'S NAME (Type) C.J. HOUMANN M.D.		22e. ADDRESS RIVERDALE MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 30 MAY 1969		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN MEM GARDENS		23d. LOCATION (City or Town) (County) (State) WILSON N. CAROLINA	
24. FUNERAL DIRECTOR W.H. Chambers Co.		ADDRESS 5801 Clarks Ave Riverdale Md		25a. REC'D BY REGISTRAR JUN 2 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
07419			Eva	NMI	Spengler	Month 5 Day 3 Year 1969		2P	
3 SEX	FEMALE		4 RACE	WHITE		5 DATE OF BIRTH	6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		IF UNDER 24 HRS HOURS MIN.	
VA.		USA				Prince George's		Md.	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp tal give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George's Gen. Hosp.			CLERICAL CLERK		U.S. Gov't	
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN	13d INS OF CITY, M.D.S?		13e. STREET AND NUMBER	
Maryland			Prince Geo.		Lanham	YES <input type="checkbox"/> NO <input type="checkbox"/>		6212 Princess Garden Pkwy	
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
William E. O'GRAY						MARY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT		Address		
NO			NO		213-48-0530 MRS. JANE PRINZ				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
PART 1. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarction</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
			HOUR A.M. Month Day Year						
			P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1-2-69, 1969, to 5-3-69, 1969, that (I) (we) last saw the deceased alive on 5-3-69, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			
A. Deitz			5/3/69			Aaron Deitz, M.D.			
22e. ADDRESS			22f. DATE SIGNED						
East-West Highway, Hyattsville, Md.			5/3/69						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL			MAY 6, 1969			F.T. LINCOLN Cem		Bladensburg, Md.	
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
LANHAM FUNERAL HOME			MAY 7 1969			Charles Judge			
LANHAM, MARYLAND									

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3 (Page 5 may be retained for your files)

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

07420

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07413

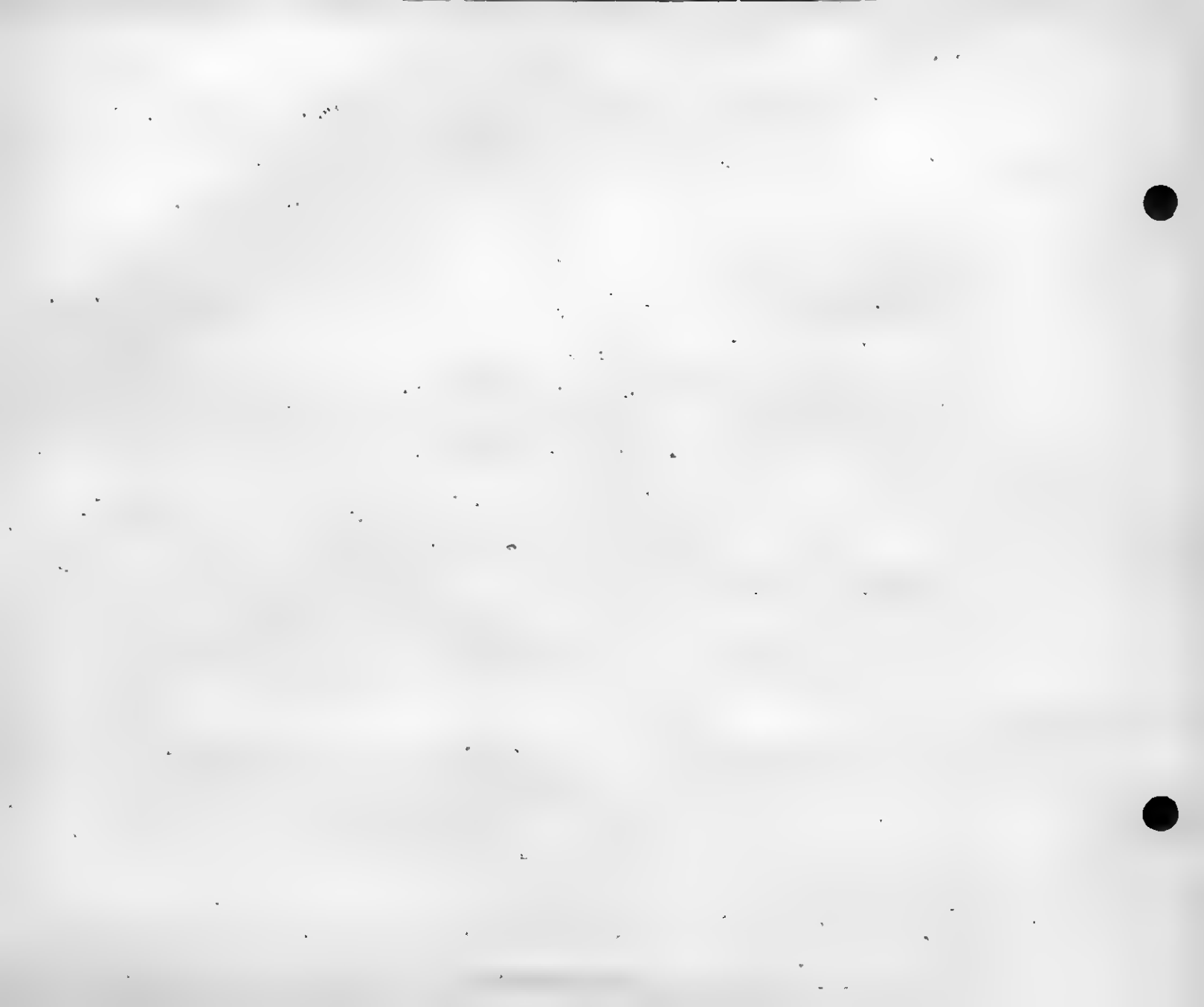
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR			
Wilda Jeanette Stewart						5-27-69			11:00am						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female		White		6-22-1917		51 YRS		MONTHS DAYS		HOURS MIN		5 Month 27 Day 69 Year		19 4:00pm	
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH			
Canada				U. S. A.								Prince George's Md.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly				2800 Crest Avenue				Housewife				Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution on residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland				Prince George's				Cheverly				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2800 Crest Avenue	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
First Middle Last				First Middle Last											
William Cowan				Lola Chilton											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT ADDRESS							
no				none				George M. Stewart Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hanging</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
				11:00am 5-27-69				Hung self at home							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State							
				Home				same as #13							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
22b. DATE SIGNED															
5-28-69															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
John Kehoe MD Riverdale, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
				ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				5/29/69		Ft. Lincoln				Colmar Manor P.G. Md.					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Francis Gasch's Sons Hyattsville, Md.						DATE JUN 2 1969				Blanche Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) First Middle Last <i>JAMES M THOMAS</i>			2a DATE OF DEATH Month Day Year <i>MAY 13 1969</i>			2b. HOUR <i>M</i>			
3 SEX <i>MALE</i>		4. RACE <i>White</i>		5 DATE OF BIRTH <i>JUNE 17 1896</i>		6. AGE (In years last birthday) <i>72</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <i>VIRGINIA</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George's</i> Md.			
10 CITY OR TOWN OF DEATH <i>Chesley</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Prince George's</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Mechanic</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Auto</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>Prince George's</i>		13c. CITY OR TOWN <i>Hyattsville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>5600 MARJOR STREET</i>	
14. FATHER'S NAME First Middle Last <i>T. E. THOMAS</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>IDA - MORRISON</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>578 03 9863</i>		17. INFORMANT <i>Julia M. Thomas</i>			Address <i>SAME AS ABOVE</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> <i>4330</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Arteriosclerosis, cerebral</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis, general</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hours</i> <i>Years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Hypertension, essential. Uremia secondary chronic obstructive urinary tract disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>25 May, 1963</i> , to <i>13 May, 1969</i> , that (I) was saw the deceased alive on <i>12 May, 1969</i> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) we <i>did</i> (did not) view the body after death.									
22b. SIGNATURE <i>J. F. Brennan, MD</i>				DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>13 May 69</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>5/16/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Colmar Manor, Md.</i>			
24. FUNERAL DIRECTOR <i>NALLEY'S FUNERAL HOME</i>				ADDRESS <i>MT Rainier, Md</i>		25a. REC'D BY REGISTRAR <i>MAY 19 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07422		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		07415	
1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Washington D.C.</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton</i>		c. LENGTH OF STAY IN 15		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince View Gardens Health Care Center</i>				d. STREET ADDRESS <i>1349 Harvard St. N.W.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Eva Thompson</i>				4. DATE OF DEATH Month <i>May</i> Day <i>14</i> Year <i>1969</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>N.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 6, 1907</i>	9. AGE (In years last birthday) <i>62</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Clinton, S. Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Willie Jack Shepherd</i>				14. MOTHER'S MAIDEN NAME <i>Mattie Cornelia Dunlap</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>Jerry Mathews</i> Address <i>1436 W. St. N.W. Washington, D.C.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. <i>4122</i> IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO (b) <i>Coronary insufficiency</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <i>Arteriosclerosis</i> <i>Cardiovascular Center</i>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebrovascular accret</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>May 6, 1969</i> to <i>May 19, 1969</i> that (I) (we) last saw the deceased alive on <i>May 15, 1969</i> , and that death occurred at <i>2:00 P.M.</i> from causes and on the date stated above.							
22a. SIGNATURE <i>Alfred R. Lapham</i> M.D.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <i>ALFRED R. LAPHAM</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>5-17-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>HARMONY PK.</i>		23d. LOCATION (City or Town) (County) (State) <i>LANDOVER, MD.</i>	
24. FUNERAL DIRECTOR <i>Rollins, Inc. 4339 Hunt Pl. N.E. D.C.</i>				25a. REC'D BY REGISTRAR DATE <i>MAY 19 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07423

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07416

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Eugenia Letitie Tirendi						May 19 1969			12:50 AM		
3 SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female	White		12-24-90			78 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md.		
Italy		U.S.A.				Prince George's					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George's Gen. Hosp.				Housewife					
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MD		Prince George's		Lanham				7707 Cross Street.			
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Michael					Candido	Mary					Ganci
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT			Address		
No						Mary T. Kearney - above address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pulmonary emboli, bilious</u> 450X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pernicious anemia, Old Fractured L hip Hypothyroid. Recent pneumonia. Acute colitis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/9</u> , 19 <u>64</u> , to <u>5/14</u> , 19 <u>64</u> , that (I) (we) lost saw the deceased alive on <u>5/14</u> , 19 <u>64</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE		Frederick H. Wilhelm MD		22c. DATE SIGNED		5/14/64					
22d. PHYSICIAN'S NAME (Type)		Frederick H. Wilhelm		22e. ADDRESS		6314 Linder Road, Cheverly Md					
23a. BURIAL, CREMATION (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		5/22/69		Calvary Cemetery		Waterbury, Conn.					
24 FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Valley's Funeral Home Inc.				Mt. Rainier, Maryland		MAY 23 1969		Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07424		CERTIFICATE OF DEATH						07417	
1. DECEASED-NAME (Type or print)				First Middle Last		2a. DATE OF DEATH Month Day Year			2b. HOUR
Julia				Frances Tolson		May 14 1969			3 10 ^M
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. YRS.
Female		White		July 28, 1893			75		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Washington D. C.		U. S. A.		Prince Georges			Md		
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR
Cheverly				Prince Geo., Gen Hosp.,			Ret. Food Manager		Capital Cafeteria
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland				Pr. Geo.		Hattsville		YES	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last			13e. STREET AND NUMBER		
William Healey				Elizabeth Ward			5305 Chesapeake Road		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17. INFORMANT Address			
no				579 03 2440A		Carl E. Tolson Same as #13 (husband)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intestinal obstruction									3 weeks
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the Pancreas with metastases									5 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Atherosclerotic heart disease and cerebrovascular disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
5/12/69		Intestinal obstruction			YES		NO		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/26, 1964, to 5/14, 1965, that (t) (we) last saw the deceased alive on 5/14, 1965, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (t) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Frederick H. Wilhelm				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/14/69			
22d. PHYSICIAN'S NAME (Type) Frederick H. Wilhelm, M.D.				22e. ADDRESS 6500 Ambler Road, Baltimore, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/16, 1969		Washington National		Suitland P. G. Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Francis Gasch's Sons Hyattsville, Md.				MAY 19 1969		Francis Gasch			

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

07425

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07418

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 5-13-69		Month	Day	Year	2b HOUR 15pm
Alice		E		Treleven						
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year	
Female	White	3-30-1893		76 YRS					5 13 69 1969 15pm	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
KENTUCKY		U.S.				Prince George's		Md.		
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Suitland		Andrews Air Force Base Hosp.		Housewife						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
District Of Columbia		Washington						6200 Oregon Ave. N.W.		
14 FATHER'S NAME		First	Middle	Lost	15 MOTHER'S MAIDEN NAME		First	Middle	Lost	
UNKNOWN		FRAMPTON			UNKNOWN		BURKE			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS				
No		340-14-8336		CAROL ROSENZWEIG		1234 CEDAR HILL LANE		Bloomfield Hills, MICH.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u>										minutes
4 DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u>										over 10 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		John Kehoe MD				M.D.		22b DATE SIGNED		
EXAMINER'S NAME (Type)		John Kehoe MD				Riverdale, Md.		5-14-69		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
CREMATION		15 MAY 1969		CEDAR HILL CREMATORY		SUITLAND MD.				
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
RINALDI FUNERAL HOME		7400 GEORGIA AVE. N.W. DC		20012		MAY 19 1969		J. Kehoe		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Nellie	Middle May	Last Umstead	2a. DATE OF DEATH Month Day Year May 16, 1969			2b. HOUR 5:45 PM
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 16, 1882		6. AGE (In years and days) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY ---			
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Bowie		13d. INSIDE CITY, Y/N? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12315 Whitehall Drive	
14. FATHER'S NAME First Middle Last Martin Rahm			15. MOTHER'S M.A.DEN NAME First Middle Last Martha Coulter						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 291-20-2382		17. INFORMANT Mildred Marin (daughter)		Address AS # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive G.I. Bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Gastritis associate with granulomatous Colitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Colitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>May 11, 1968</u> to <u>May 16, 1969</u> , that (I) (we) last saw the deceased alive on <u>May 14, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Leonard P. Appel</u>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) Leonard P. Appel, M.D.		22e. ADDRESS 3231 Superior Lane, Bowie, Md. 20715		22c. DATE SIGNED 5/18/69					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5-21-1969		23c. NAME OF CEMETERY OR CREMATORY West Park Cemetery		23d. LOCATION (City or Town) (County) (State) Cleveland, Ohio			
24. FUNERAL DIRECTOR <u>W. W. Chambers & Co.</u>		ADDRESS <u>Bowen, Md.</u>		25a. REC'D BY REGISTRAR DATE MAY 20 1969		25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>			

1539

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
07427		07428							
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Elwood G. Valentine						Month Day Year			9:40 AM
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		7. IF UNDER 24 HRS	
M	W		July 19, 1886			82 YRS.		MONTHS DAYS HOURS M.N.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsylvania		USA				Prince Georges Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Accokeek			Residence			Machinist			Wash Terminal
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Md			PG			Accokeek		RFD 2 Box 121	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
George Valentine				- Campbell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT Address			
no			718-14-9823			Gertrude G. Mahan, Daughter 4908 Kirby Road, Clinton, Md., 20735			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Infection</u>									1 Day
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of Bowel</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Brain Cancer & Alcoholic</u>									year
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or RFD No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 4-10, 1966, to 5-17, 1969, that (I) (we) lost saw the deceased alive on 5-16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert E. Wilhelm</u>					DEGREE ATTENDING PHYS		MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/21/69		Cedar Hill Cemetery		Suitland, Maryland, 20023			
24. FUNERAL DIRECTOR Robert E. Wilhelm, Funeral Home					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
433 Suitland Road, S.E., Suitland, Md., 20023					MAY 22 1969		R. Charles Judge		

1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
HARRY FREDRICK VOLKMAN						MAY 12 Day 69 Year		1140 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		Caucasian		5 Jun 1898		70 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Washington DC		U.S.A.				PRINCE GEORGES Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
ANDREWS AFB		MALCOLM GROW USAFHOSP		RETIRED					
13a. USUAL RESIDENCE (Where deceased lived, if inst. nat. on. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		PRINCE GEORGE		FORESTVILLE X				8304 DONNELL PL #C-5	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Harry F. Volkman			Susan Benson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT Address				
YES			577-40-9549		Wife same as item # 13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>									5 Minutes
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Severe pulmonary insufficiency</u>									1 Month
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>chronic obstructive emphysema</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
<u>Severe arteriosclerosis generalized</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
24 Apr 69		undiagnosed pulmonary infiltrate of ? etio.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		no		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>8 Apr</u> , 19 <u>69</u> , to <u>12 May</u> , 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>12 May</u> , 19 <u>69</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE <u>Richard Flax MD</u>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED		
RICHARD FLAX, CAPT USAF MC							12 May 69		
22d. ADDRESS					22e. ADDRESS				
MALCOLM GROW USAFHOSP ANDREWS AFB									
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
XXXXXX		May 16-69		Arlington Natl. Cemetery, Arlington, Va					
24 FUNERAL DIRECTOR <u>Simmons Bros</u>		ADDRESS <u>Wash.,</u>		25a. REC'D BY REGISTRAR <u>MA 14 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			
<u>Simmons Bros. 1661-Gd. Hope Rd. SE.DC</u>									

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VR AIS
45M

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
07429		07422									
1 DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH			2b HOUR
George		M.		Waterholter				May 12 1969			5 A M
3 SEX		4. RACE		5 DATE OF BIRTH				6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		06-10-18				50 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
Washington, D.C.		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's Md.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince George's Gen. Hosp.				Construction					
13a U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
MD		Prince George's		District Hgt.				5409 Walkermill Road			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MA DEN NAME		First Middle Last	
George		Waterholter						Martha		Bell Rowley	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT Address					
no						Kelsey Johnson 1431 Ridge Pl S.E D.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Asphyxial arrest</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Obstruction of right main bronchi</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>bronchogenic CA.</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
MEDICAL CERTIFICATION											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)							
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (this hospital) attended the deceased from May 7, 1969, to May 12, 1969, that (I) (we) lost saw the deceased alive on May 12, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death											
22b SIGNATURE		22c DATE SIGNED				22d PHYSICIAN'S NAME (Type)					
						Luis Bentalila, M.D.					
22d PHYSICIAN'S NAME (Type)		22e ADDRESS				22f ADDRESS					
						Prince George's Gen. Hosp.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)			
Burial		5/15/69		Washington Natl Cemetery Suitland				Maryland			
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE					
Lee Funeral Home		4th & MASS AVE N.E. WASHINGTON DC				MAY 16 1969					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV 14

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07430					07423				
1 DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last					Month Day Year			Hour Min	
Margaret M. Weishaupt					May 15 1969			6:55A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		04-10-13		56 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Wash. D. C.		U. S. A.				Prince George's Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George's Gen. Hosp		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD		Prince George		Bladensburg				4208 54th Place	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Thomas Lavender				Regina Murphy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
No		213-54-9585		Robert A. Weishaupt Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ischemic heart disease</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension + yellow atrophy</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 mo.</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/19/69</u> , 19 <u>69</u> , to <u>5/15/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/11/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Frederick E. Musser</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>5/15/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Frederick E. Musser, MD.</u>				22e. ADDRESS <u>4410 74th Ave., Hyattsville, MD</u>					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5-17-69		Ft Lincoln Cemetery		Bladensburg Maryland			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
<u>Francis Collins 500 Univ. Blvd. W. Sd. & Kd</u>				MAY 20 1969		<u>[Signature]</u>			

5730

4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07431

CERTIFICATE OF DEATH

07424

1 DECEASED-NAME (Type or print) , JOSEPH J		First Middle Last		2a. DATE OF DEATH Month Day Year May 18, 1969		2b. HOUR a m 0945	
3 SEX Male		4 RACE Cau		5. DATE OF BIRTH March 18, 1930		6. AGE (In years last birthday) 39 YRS	
7a BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md	
10 CITY OR TOWN OF DEATH Andrews Air Force Base		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Civil Service		12b. KIND OF BUSINESS OR INDUSTRY USAF	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 10906 Tyrone Drive		14 FATHER'S NAME First Middle Last Joseph Welsh		15. MOTHER'S MAIDEN NAME First Middle Last Sylvia Russo			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO 1948 - 1968 101-22-3340		17. INFORMANT 10906 Tyrone Drive Joan N. Welsh Upper Marlboro, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) } (b) <u>acute myocardial infarction 2 hours</u> stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 18 May, 1969, to 18 May, 1969, that (I) (we) lost saw the deceased alive on 18 May, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Burton Sack MD DEGREE				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 18 May 1969	
22d. PHYSICIAN'S NAME (Type) BURTON SACK, MD				22e. ADDRESS Malcolm Grow USAF Hospital Andrews AFB, Washington, DC 20331			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/21/69		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION (City or Town) (County) (State) Clinton, Md.	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4303 Suitland Rd., S.E., Suitland, Md., 20023				25a. REC'D BY REGISTRAR MAY 22 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

07425

1. DECEASED-NAME (Type or print)		First SHELTON		Middle L		Last WHARTON		2a. DATE OF DEATH MAY Month 30 Day 69 Year		2b. HOUR A 8:15 M	
3 SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH Aug. 10th 1927		6. AGE (In years last birthday) 41 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE Md.					
10. CITY OR TOWN OF DEATH ANDREWS AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW USAFHOSP		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) AIR FORCE		12b. KIND OF BUSINESS OR INDUSTRY AIR FORCE					
13a. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE MARYLAND		13b. CITY OR TOWN PRINCE GEORGE'S		13c. CITY OR TOWN ANDREWS AFB		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3776-7 LOUISIANA DRIVE			
14. FATHER'S NAME First Middle Last Unknown				15. MOTHER'S MA DEN NAME First Middle Last Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) (If yes give war or dates of service) YES		16b. SOCIAL SECURITY NO 218-20-3096		17. INFORMANT Address Lillian M. Wharton Home #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION WITH CHF AND DUE TO, OR AS A CONSEQUENCE OF (b) SHOCK DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HRS 5 YEARS										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (X) (this hospital) attended the deceased from 29 May , 19 69 , to 30 May , 19 69 , that (X) (we) lost saw the deceased alive on 30 May , 19 69 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (d did not) view the body after death.											
22b. SIGNATURE David Rosenthal				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22c. DATE SIGNED 30 May 69			
22d. PHYSICIAN'S DAVID ROSENTHAL MAJ USAF MC				22e. ADDRESS MALCOLM GROW USAF HOSP ANDREWS AFB							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-7-69		23c. NAME OF CEMETERY OR CREMATORY W. W. Chambers Co. 517-11th St. S.E.		23d. LOCATION (City or Town) (County) (State) Snow Hill Md.		25a. REC'D BY REGISTRAR DATE JUN 9 1969			
24. FUNERAL DIRECTOR W. W. Chambers Co. 517-11th St. S.E.		25b. REGISTRAR'S SIGNATURE W. W. Chambers									



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>07433</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>07426</div>											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Nellie			C. R.			Like			<input checked="" type="checkbox"/> Month Day Year 5-1-69 19		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Female		23 JULY-25 43 YRS				MONTHS DAYS		HOURS MIN		Month 5 Day 1 Year 19 69 1:05 a.m.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH		
Virginia			U.S.A.			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			Prince George		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Virginia			Henry			Bassett			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Rt. 3		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMOED FORCES?			16b. SOCIAL SECURITY NO.		
Elige			Gladys			(Yes, no, or unknown) No			(If yes give war or dates of service) 228 28 0308		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Blevins			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 8121 DUE TO, OR AS A CONSEQUENCE OF (b) Burns 3rd degree 50% of body surface 13 hrs DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
			9:00am 4-30-69			Passenger in truck involved in collision					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No. City or Town County State					
			Street			Rt 495 at Rt 214, Prince George Co., Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL EXAMINER'S SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED		
John Kehoe			John Kehoe, N.D., Riverdale, Md.			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			501069 5-1-69		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			5/5/1969			Henry Memorial Gardens Co. Bassett			Henry Virginia		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Nalleys Funeral Home			Mt Rainier Md			MAY 5 1969			J. Charles Yunge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07434

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07427

1. DECEASED NAME (Type or print) First Middle Last <i>Ethel G. Wilson</i>			2a. DATE OF DEATH Month Day Year <i>May 7 1969</i>			2b. H.O.J.R. <i>106 3/4 M</i>							
3 SEX <i>Female</i>		4 RACE <i>Negro</i>		5 DATE OF BIRTH <i>Sept. 13, 1893</i>		6 AGE (In years last birthday) <i>75 YRS.</i>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince Georges</i> Md.							
10. CITY OR TOWN OF DEATH <i>Clinton</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Pine View Gardens</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>D.C.</i>			13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1520-8350 N.W. Wash. D.C.</i>				
14. FATHER'S NAME First Middle Last <i>Joseph Garnett</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Harriett J. Cleveland</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <i>578-30-3243</i>		17. INFORMANT <i>Mr. Duane Garnett</i>			Address <i>1002 Douglas St. N.E. Wash. D.C.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary occlusion</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebrovascular lesions of the arteries.</i> (and if any, which gave rise to immediate cause (a), stating the underlying cause last)												APPROX. DATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hr.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>decubiti sacral area and anoxemia</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>3-17, 1969</i> , to <i>4-7, 1969</i> , that (I) (we) lost saw the deceased alive on <i>4-7, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Alfred R. Lapina</i>						DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4/7/69</i>			
22d. PHYSICIAN'S NAME (Type) <i>ALFRED R. LAPINA</i>						22e. ADDRESS <i>CLINTON, MD</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>5-12-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Memorial</i>			23d. LOCATION (City or Town) (County) (State) <i>Suitland - Md</i>					
24. FUNERAL DIRECTOR <i>William Spangler</i>						ADDRESS <i>524-8726</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 12 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
07435					07428						
1 DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR				
First Middle Last Herman Windsor					Month Day Year May 10 1969		9:20 PM				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR			
Male		colored		03-01-15		54 YRS.		MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Prince Geo's Co		U.S.A.				Prince George's Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's Gen. Hosp.								
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d NO. OF CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Prince George's			Upper Marlboro					
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
Clarence Windsor			Ida Estelle Harper								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
Yes, no, or unknown						Marion Spencer					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) massive pulmonary edema											
DUE TO, OR AS A CONSEQUENCE OF cardiac failure											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f LOCATION Street or R.F.D. No.		City or Town		County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-10-69, 1969, to 5-10-69, 1969, that (I) (we) last saw the deceased alive on 5-10-69, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Longoria / M. Longoria DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22c DATE SIGNED											
22d. PHYSICIAN'S NAME (Type) Dr. Ricardo Longoria M.D. 22e ADDRESS 6001 Landover Rd. Cheverly, Md.											
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		May 15/69		Brooks Ch. Cemetery		Nottingham, P. Co. Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Martell C. Brown		Crownsville, Md.		MAY 21 1969		Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07436

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07429

1 DECEASED NAME (Type or print) Howard		First Howard	Middle B.	Last Windsor	2a. DATE OF DEATH Month May Day 7 Year 1969		2b HOUR 4 A M
3 SEX Male	4. RACE White		5. DATE OF BIRTH 07-28-1900		6 AGE (In years last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md.		
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Plumber		12b KIND OF BUSINESS OR INDUSTRY Plumbing	
13a USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b COUNTY Prince George's		13c CITY OR TOWN Glen Dale	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 9920 Franklin Ave. East	
14. FATHER'S NAME First Eugene		Middle Windsor	Last Frances		15 MOTHER'S MAIDEN NAME First Middle Ferguson		
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes give war or dates of service) Yes		WW 11		16b. SOCIAL SECURITY NO 577 42 8393	17 INFORMANT Frank E. Gasch 4002 48th Street Bladensburg, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a): stating the underlying cause lost. (b) <u>and Ductal ectasia - bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION 4-21-69		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Massive GI. bleed		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCAT ON Street or R.F.D. No City or Town County State			
22a. I certify that XX (this hospital) attended the deceased from April 19, 19 69, to May 7, 1969, that XX (we) last saw the deceased alive on May 7, 19 69, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE A. S. Banisar M.D.				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-7-69	
22d. PHYSICIAN'S NAME (Type) A. S. Banisar, M.D.				22e. ADDRESS 6323 Landover Rd. Cheverly, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 5/10/69		23c NAME OF CEMETERY OR CREMATORY Cedar Hill		23d LOCATION (City or Town) (County) (State) Suitland P. G. Md.	
24. FUNERAL DIRECTOR ADDRESS Francis Gasch's Sons Hyattsville, Maryland				25a RECD BY REGISTRAR MAY 9 1969		25b REGISTRAR'S SIGNATURE Francis Gasch	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 2 Filing 5/2/69 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07437 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07430									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Ifene			M.			Witherspoon		May 16 1969 6:00 PM	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	8-9-05	63 YRS			Month 5 Day 16 Year 1969		7:16 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Penna.		USA				Prince George's Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Oxon Hill		5200 Westfield Drive				Held-Riplinger News Agency			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland			Prince Geo.			Oxon Hill		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			
First Middle Last			First Middle Last			5200 Westfield Drive			
Zachary T. Miller			Jennie			Aulthouse			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			
NO			579 01 0936			John S. Witherspoon			
16c. ADDRESS			17 ADDRESS						
Oxon Hill, Md			5200 Westfield Dr						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Pulmonary edema and congestion</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Acute congestive heart failure</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Hypertensive cardiovascular disease</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. P.M.		19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		Victor A. Fazekas, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		5-17-69	
				Prince Geo. Gen. Hosp					
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		5-19-69		Cedar Hill Cemetery		Suitland, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Simmons Bros		XXXXXX		MAY 19 1969					
1661 Good Hope Rd SE Wash DC									

5718

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

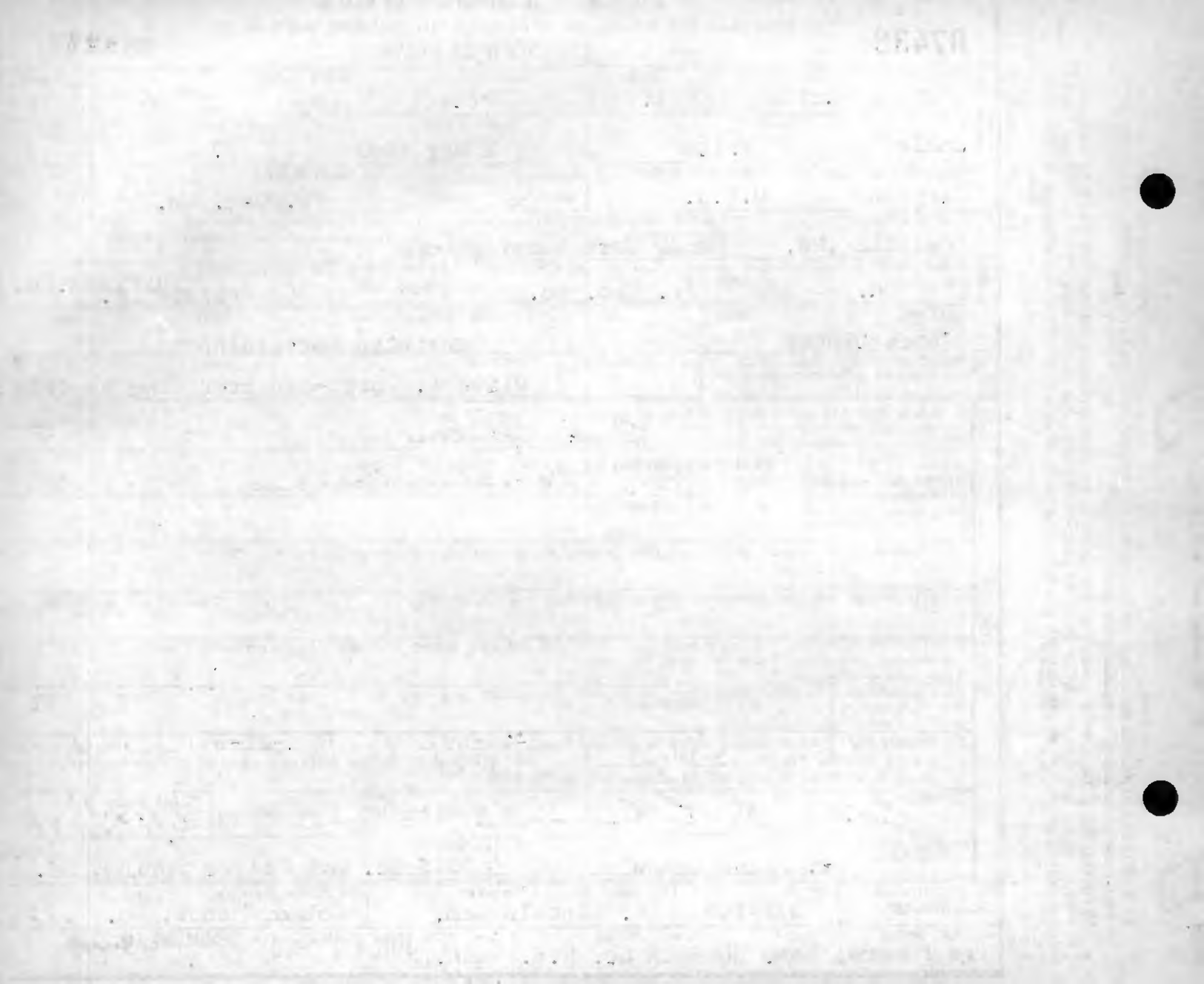
07438

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08921

1. DECEASED-NAME (Type or print) Carrie L. Yates			2a. DATE OF DEATH Month May Day 21 Year 69			2b. HOUR 10 P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 2 May 1892		6. AGE (In years lost birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Pr. Geo. Co. Md.			
10. CITY OR TOWN OF DEATH Adelphia, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Manor Care Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Pr. Geo. Co.		13c. CITY OR TOWN Suitland, Md.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3303 Terrace Dr.	
14. FATHER'S NAME First James Middle Dingee			15. MOTHER'S MAIDEN NAME First Henrietta Middle Chesildine			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown?			
16b. SOCIAL SECURITY NO.			17. INFORMANT Address Olive L. Wortz-daughter Same as #13d			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Swai Jarlue 5718 DUE TO, OR AS A CONSEQUENCE OF (b) Heart Cribosis DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3-14-69 , 19__, to 5-21-69 19__, that (I) (we) last saw the deceased alive on 5-19-69 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. Allan Cohan				22c. DATE SIGNED 6/12/69		22d. PHYSICIAN'S NAME (Type) Dr. Allan Cohan			
22e. ADDRESS 13515 Ga. Ave Silver Spring, Md.									
23a. BURIAL, CREMATION, <input checked="" type="checkbox"/> REMOVAL (Specify)		23b. DATE 5/24/69		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.			
24. FUNERAL DIRECTOR ADDRESS Lee Funeral Home 300-4th St. N.E. Wash D.C.				25a. RECEIVED BY REGISTRAR JUN 13 1969		25b. REGISTRAR'S SIGNATURE [Signature]			



185X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07439

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07431

1. DECEASED NAME (Type or print) <i>Lloyd</i> First <i>Young</i> Middle <i>Young</i> Last		2a. DATE OF DEATH Month <i>5</i> - Day <i>17</i> - Year <i>1969</i>		2b. HOUR M
3. SEX <i>Male</i>	4. RACE <i>Col.</i>	5. DATE OF BIRTH <i>6-9-1910</i>	6. AGE (In years In () - Mo () - Yr () <i>58</i> YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Prince George</i> Md.	
10. CITY OR TOWN OF DEATH <i>Chesley</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Prince George</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Farming</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Prince George</i>	13c. CITY OR TOWN <i>Upper Marlboro</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>R. 2 - Box 119</i>
14. FATHER'S NAME <i>Earnest</i> First <i>Young</i> Middle <i>Young</i> Last	15. MOTHER'S MAIDEN NAME, First <i>Elizabeth</i> Middle <i>Taylor</i> Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO. <i>21326863</i>	17. INFORMANT <i>Ethel Savoy</i> Address <i>Upper Marlboro Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac + Respiratory arrest</i> <i>185X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Malignant Ca of Prostate gl.</i> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Anemia 27 to Malignant</i>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Shipavan Tharunsky</i>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <i>5-17-69</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>5-21-1969</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>	23d. LOCATION (City or Town) <i>Annapolis</i>	(County) (State)
24. FUNERAL DIRECTOR <i>Richard Bennett</i>		ADDRESS <i>Home Annapolis</i>	25a. REC'D BY REGISTRAR DATE <i>MAY 20 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

07433

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